Therapy Provider Training

Provider Type 34
Objectives
Objectives

- Locate Medicaid Policy
- Locate Prior Authorization Forms
- Login to the Electronic Verification System (EVS) secure Provider Web Portal
- Successfully Submit a Prior Authorization
- View Prior Authorizations
- Locate Billing Information
- Utilize the Search Fee Schedule and DHCFP Rates Unit
- Submit Claims using Direct Data Entry via the EVS secure Provider Web Portal
Medicaid Website
EVS is available 24 hours a day, seven days a week except during the scheduled weekly maintenance period.

System Requirements

To access EVS, user must have internet access and a computer with a web browser. (Microsoft Internet Explorer 9.0 or higher recommended)
Medicaid Services Manual (MSM)
Locating Medicaid Services Manual (MSM)

- Step 1: Highlight “Quick Links” from top blue toolbar at www.medicaid.nv.gov.
- Step 2: Select “Medicaid Services Manual” from the drop-down menu.
- Note: MSM Chapters will open in new webpage through the DHCFP website.
Locating MSM, continued

- Medicaid Services Manual - Complete
- 100 Medicaid Program
- 200 Hospital Services
- 300 Radiology Services
- 400 Mental Health and Alcohol and Substance Abuse Services
- 500 Nursing Facilities
- 600 Physician Services
- 700 Reimbursement, Analysis and Payment
- 800 Laboratory Services
- 900 Private Duty Nursing
- 1000 Dental
- 1100 Ocular Services
- 1200 Prescribed Drugs
- 1300 DME Disposables Supplies and Supplements
- 1400 Home Health Agency
- 1500 Healthy Kids Program
- 1600 Intermediate Care for Individuals with Intellectual Disabilities

- 1700 Therapy
- 1800 Adult Day Health Care
- 1900 Transportation Services
- 2000 Audiology Services
- 2100 Home and Community Based Waiver for Individuals with Intellectual Disabilities
- 2200 Home and Community Based Waiver for the Frail Elderly
- 2300 Waiver for Persons with Physical Disabilities
- 2400 Home Based Habilitation Services
- 2500 Case Management
- 2600 Intermediary Service Organization
- 2700 Certified Community Behavioral Health Clinic
- 2800 School Based Child Health Services
- 3000 Indian Health
- 3100 Hearings
- 3200 Hospice
- 3300 Program Integrity
- 3400 Telehealth Services
- 3500 Personal Care Services Program
- 3600 Managed Care Organization
- 3800 Care Management Organization
- 3900 Home and Community Based Waiver for Assisted Living
- Addendum

- Select “1700 Therapy”
- From the next page, always make sure to select the “Current” policy
Prior Authorization (PA) Forms
Locating Prior Authorization Forms

- Step 1: Highlight “Providers” from top blue tool bar.
- Step 2: Select “Forms” from the drop-down menu.
Locating Prior Authorization Forms, continued

- While on the “Forms” page, locate the FA-7 form.
- Follow the instructions on the form.
- All active forms are fillable for easy uploading for PA submission online.
- Any form that is not legible will not be accepted.

<table>
<thead>
<tr>
<th>Form Number</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>FA-1</td>
<td>Durable Medical Equipment Prior Authorization Request</td>
</tr>
<tr>
<td>FA-1A</td>
<td>Usage Evaluation for Continuing Use of BiPAP and CPAP Devices</td>
</tr>
<tr>
<td>FA-1B</td>
<td>Mobility Assessment and Prior Authorization (PA), Revised 12/29/10</td>
</tr>
<tr>
<td>FA-1B INSTRUCTIONS</td>
<td>Mobility Assessment and Prior Authorization (PA) Instructions</td>
</tr>
<tr>
<td>FA-1C</td>
<td>Oxygen Equipment and Supplies Prior Authorization Request</td>
</tr>
<tr>
<td>FA-1D</td>
<td>Wheelchair Repair Form</td>
</tr>
<tr>
<td>FA-3</td>
<td>Inpatient Rehabilitation Referral/Assignment</td>
</tr>
<tr>
<td>FA-4</td>
<td>Long Term Acute Care Prior Authorization</td>
</tr>
<tr>
<td>FA-6</td>
<td>Outpatient Medical/Surgical Services Prior Authorization Request</td>
</tr>
<tr>
<td>FA-7</td>
<td>Outpatient Rehabilitation and Therapy Services Prior Authorization Request</td>
</tr>
<tr>
<td>FA-8</td>
<td>Inpatient Medical/Surgical Prior Authorization Request</td>
</tr>
<tr>
<td>FA-8A</td>
<td>Induction of Labor Prior to 39 Weeks and Scheduled Elective C-Sections</td>
</tr>
<tr>
<td>FA-10A</td>
<td>Psychological Testing</td>
</tr>
<tr>
<td>FA-10B</td>
<td>Neuropsychological Testing</td>
</tr>
<tr>
<td>FA-10C</td>
<td>Developmental Testing</td>
</tr>
<tr>
<td>FA-10D</td>
<td>Neurobehavioral Status Exam</td>
</tr>
<tr>
<td>FA-11</td>
<td>Outpatient Mental Health Request</td>
</tr>
<tr>
<td>FA-11A</td>
<td>Behavioral Health Authorization</td>
</tr>
<tr>
<td>FA-11D</td>
<td>Substance Abuse/Behavioral Health Authorization Request</td>
</tr>
<tr>
<td>FA-11E</td>
<td>Applied Behavior Analysis (ABA) Authorization Request</td>
</tr>
<tr>
<td>FA-11F</td>
<td>Autism Spectrum Disorder (ASD) Diagnosis Certification for Requesting Initial Applied Behavior Analysis (ABA) Services</td>
</tr>
<tr>
<td>FA-12</td>
<td>Inpatient Mental Health Prior Authorization</td>
</tr>
</tbody>
</table>
Outpatient Rehabilitation and Therapy (FA-7) – Page 1

- Date of Request
- Request Type
- Enter all applicable information for:
  - Recipient
  - Ordering Provider
  - Servicing Provider
  - Clinical Information

### Nevada Medicaid Therapy Provider Training

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### Outpatient Rehabilitation and Therapy

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

Required documentation which must be uploaded and submitted with this form:
- Plan of Care (POC) must include deficits, chronic or acute, short-term and long-term goals, and goal and progress toward goals
- Doctor’s order

Authorization is limited to a 90-day period for recipients age 21 and older and a 180-day period for recipients under age 21. If the doctor’s order is for one year, the same order can be attached.

**DATE OF REQUEST:** ____________

**REQUEST TYPE:** ☐ Prior Authorization ☐ Continued Services ☐ Retrospective Review

**REQUIRED FOR RETROSPECTIVE REVIEWS ONLY**
This recipient was determined eligible for Medicaid benefits on: ________/______/_________

**NOTES:**

<table>
<thead>
<tr>
<th>RECIPIENT INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name (Last, First, MI):</td>
</tr>
<tr>
<td>Address (Include city, state, zip):</td>
</tr>
<tr>
<td>Medicare Insurance Information:</td>
</tr>
<tr>
<td>Other Insurance Name:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ORDERING PROVIDER INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>NPI:</td>
</tr>
<tr>
<td>Address (Include city, state, zip):</td>
</tr>
<tr>
<td>Contact Name:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SERVICING PROVIDER INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>NPI:</td>
</tr>
<tr>
<td>Address (Include city, state, zip):</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CLINICAL INFORMATION</th>
<th>Use additional sheet(s) if needed to submit all pertinent medical documentation and justification to be considered in the determination of this request.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this request for Healthy Kids (EPSDT) referral/services?</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Diagnosis (include ICD-10 codes and descriptions):</td>
<td></td>
</tr>
</tbody>
</table>

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FA-7
01/26/2015 rev 10/30/2018

Page 1 of 2

Nevada Medicaid Therapy Provider Training
Outpatient Rehabilitation and Therapy (FA-7) – Page 2

- Fill out all Requested Services (Enter one code per line)
- Enter all applicable information for:
  Functional Deficits & Rehab Diagnosis
  Treatment Goals
  Previous Service or Treatment
  Other Clinical Information
Submitting a Prior Authorization via the EVS Secure Provider Web Portal
Once registered, users may access their accounts from the Provider Web Portal (PWP) “Home” page by:

- Entering the **User ID**.
- Clicking the **Log In** button.
Logging in to the Provider Web Portal, continued

Once the user has clicked the Log In button, the user will need to provide identity verification as follows:

- Answer the **Challenge Question** to verify identity.
- Choose whether log in is on a **personal computer** or **public computer**.
- Click the **Continue** button.
Logging in to the Provider Web Portal, continued

The user will continue providing identity verification as follows:

6. Confirm that the Site Key and Passphrase are correct
7. Enter Password
8. Click the Sign In button

NOTE: If this information is incorrect, users should not enter their password. Instead, they should contact the help desk by clicking the Customer help desk link.
Welcome Screen

Once the provider information has been verified, the user may explore the features of the PWP, including:

A. Additional tabs for users to research eligibility, submit claims and PAs, access additional resources, and more.
B. Important broadcast messages.
C. Links to contact customer support services.
D. Links to manage user account settings, such as passwords and delegate access.
E. Links to additional information regarding Medicaid programs and services.
F. Links to additional PWP resources.
Navigating the Provider Web Portal

The tabs at the top of the page provide users quick access to helpful pages and information:

A. **My Home**: Confirm and update provider information and check messages.
B. **Eligibility**: Search for recipient eligibility information.
C. **Claims**: Submit claims, search claims, view claims and search payment history.
D. **Care Management**: Request PAs, view PA statuses and maintain favorite providers.
E. **File Exchange**: Upload forms online.
F. **Resources**: Download forms and documents.
G. **Switch Providers**: This is where delegates can switch between providers to whom they are assigned. The tab is only present when the user is logged in as a delegate.
Care Management Tab

Create Authorization
— Create authorizations for eligible recipients

View Authorization Status
— Prospective authorizations that identify the requesting or servicing provider

Maintain Favorite Providers
— Create a list of frequently used providers
— Select the facility or servicing provider from the providers on the list when creating an authorization
— Maintain a favorites list of up to 20 providers
Before You Create a Prior Authorization Request
Verify eligibility to ensure that the recipient is eligible on the date of service for the requested services.

Use the Provider Web Portal’s PA search function to see if a request for the dates of service, units and service(s) already exists and is associated with your individual, state or local agency, or corporate or business entity.

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

Use the Provider Web Portal to check PAs in pending status for additional information.
Create a Prior Authorization Request
Key Information

Recipient Demographics
— First Name, Last Name and Birth Date will be auto-populated based on the recipient ID entered.

Diagnosis Codes
— All PAs will require at least one valid diagnosis code.

Searchable Diagnosis, Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS)
— Enter the first three letters or the first three numbers of the code to use the predictive search.

PA Attachments
— Attachments are required with all PA requests. Attachments can only be submitted electronically.
— PA requests received without an attachment will remain in pended status for 30 days.
— If no attachment is received within 30 days, the PA request will automatically be canceled.
Submitting a PA Request

1. Hover over the Care Management tab.
2. Click Create Authorization from the sub-menu.
Submitting a PA Request, continued

3. Select the authorization type (Medical).
4. Choose an appropriate **Process Type** from the drop-down list (Outpt M/S).
Submitting a PA Request, continued

5. The **Requesting Provider Information** is automatically populated with the Provider ID and Name of the provider that the signed-in user is associated with.
Submitting a PA Request, continued

6. Enter the **Recipient ID**. The Last Name, First Name and Birth Date will populate automatically.
Submitting a PA Request, continued

7. Enter **Referring Provider Information** using one of three ways
Submitting a PA Request, continued

A. Check the **Referring Provider Same as Requesting Provider** box.
B. Choose an option from the **Select from Favorites** drop-down. This drop-down displays a list of providers that the user has indicated as favorites.
C. Enter the **Provider ID** and **ID Type**. Both fields must be completed when using this option.
D. Click the **Add to Favorites** checkbox. Use this after entering a provider ID to add it to the **Select from Favorites** drop-down.
Submitting a PA Request, continued

8. Enter Service Provider Information.

Nevada Medicaid Therapy Provider Training
9. Select a **Diagnosis Type** from the drop-down list.

10. Enter the **Diagnosis Code**. Once the user begins typing, the field will automatically search for matching codes.

11. Click the **Add** button.

**NOTE:** Repeat steps 9-11 to enter up to nine codes. The first code entered will be considered the primary.
If you click the **Add** button with an invalid diagnosis code, an error will display. You must ensure the diagnosis code is correct, up-to-date with the selected **Diagnosis Type**, and does not include decimals.
Once a diagnosis code has been entered accurately, and the **Add** button has been clicked, the diagnosis code will display under the **Diagnosis Information section**. If a code needs to be removed from the PA request, click **Remove** located in the **Action** column.
12. Enter details regarding the service(s) provided into the Service Details section.
13. Click the Add Service button.
After clicking the **Add Service** button, the service details will display in the list.

**NOTE:** Manage additional details as needed. If a user wishes to copy a service detail, click **Copy** located in the **Action** column. To remove the detail, click **Remove**.
Submitting a PA Request, continued

The **Transmission Method** will default to EL-Electronic Only as attachments must be sent via the Provider Web Portal.
14. Choose the type of attachment being submitted from the Attachment Type drop-down list.
15. Click the **Browse** button.
16. Select the desired attachment.
17. Click the **Open** button.

Allowable file types include: .doc, .docx, .gif, .jpeg, .pdf, .txt, .xls, .xlsx, .bmp, .tif, and .tiff.
18. Click the **Add** button.
Submitting a PA Request, continued

The added attachment displays in the list.

To remove the attachment, click Remove in the Action column.

Add additional attachments by repeating steps 14-18.

NOTE: The total attachment file size limit before submitting a PA is 4 MB. When more attachments are needed beyond this capacity, the user will first submit the PA. Afterwards, go back into the PA using the View Authorization Response page, click the edit button to open the PA and then add more attachments.
Submitting a PA Request, continued

19. Click the **Submit** button.
Submitting a PA Request, continued

20. Review the information on the PA request.

21. Click the Confirm button to submit the PA for processing. Only click the Confirm button once. If a user clicks Confirm multiple times, multiple PAs will be submitted and denied due to multiple submissions.

NOTE: If updates are needed prior to clicking the Confirm button, click the Back button to return to the “Create Authorization” page.
After the Confirm button has clicked, an “Authorization Tracking Number” will be created. This message signifies that the PA request has been successfully submitted.
A. **Print Preview**: Allows a user to view the PA details and receipt for printing.
B. **Copy**: Allows a user to copy member or authorization data for another authorization.
C. **New**: Allows a user to begin a new PA request for a different member.
Viewing Status
Viewing the Status of PAs

1. Hover over the Care Management tab.
2. Click View Authorization Status.
Viewing the Status of PAs, continued

3. Click the ATN hyperlink of the PA to be viewed.
Viewing the Status of PAs, continued

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

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

- **Certified in Total**: The PA request is approved for exactly as requested.
- **Certified Partial**: The PA request has been approved, but not as requested.
- **Not Certified**: The PA request is not approved.
- **Pended**: The PA request is pending approval.
- **Cancel**: The PA request has been canceled.
Viewing the Status of PAs, continued

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

<table>
<thead>
<tr>
<th>C. From Date</th>
<th>D. To Date</th>
<th>E. Units</th>
<th>F. Remaining Units</th>
<th>G. Amount</th>
<th>H. Code</th>
<th>I. Medical Citation</th>
<th>J. Decision / Date</th>
<th>K. Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/12/2018</td>
<td>01/12/2019</td>
<td>10</td>
<td>10</td>
<td>–</td>
<td>CPT/HCPCS 0003F-INACTIVE TOBACCO USE, NON-SMOKING</td>
<td>Certified In Total 01/12/2018</td>
<td>–</td>
<td></td>
</tr>
</tbody>
</table>

C. **From Date** and **To Date**: Display the start and end dates for the PA.

D. **Units**: Displays the number of units originally on the PA.

E. **Remaining Units** or **Amount**: Display the units or amount left on the PA as claims are processed.

F. **Code**: Displays the CPT/HCPCS code on the PA.

G. **Medical Citation**: Indicates when additional information is needed for authorizations (including denied).
The Medical Citation field indicates if additional information is needed for all authorizations (including denied). Click “View” to see the details and clinical notes provided by Nevada Medicaid or click “Hide” to collapse the information panel.
Viewing the Status of PAs, continued

H. **Edit**: Edit the PA.
I. **View Provider Request**: Expand all sections to view the information.
J. **Print Preview**: Display a printable version of the PA with options to print.
Searching for PAs
Searching for PAs

1. Click the **Search Options** tab.
2. Enter search criteria into the search fields.
Searching for PAs, continued

A. **Authorization Tracking Number**: Enter the ATN to locate a specific PA.

B. **Day Range**: Select an option from this list to view PA results within the selected time period.

C. **Service Date**: Enter the date of service to display PA with that service date.

NOTE: Without an ATN, a **Day Range** or a **Service Date** must be entered. If the PA start date is more than 60 days ago, a **Service Date** must be entered.
Searching for PAs, continued

D. **Status:** Select a status from this list to narrow search results to include only the selected status.
E. **Recipient ID**: Enter the unique Medicaid ID of the client.

F. **Birth Date**: Enter the date of birth for the client.

G. **Last Name** and **First Name**: Enter the client’s first and last name.

**NOTE**: Enter only the **Recipient ID** number or the client’s last name, first name and date of birth.
Searching for PAs, continued

H. **Provider ID**: Enter the provider’s unique National Provider Identifier (NPI).

I. **ID Type**: Select the provider’s ID type from the drop-down list.

J. **This Provider is the**: Select whether the provider is the servicing or referring provider on the PA request.
Searching for PAs, continued

3. Click the **Search** button.
4. Select an **ATN** hyperlink to review the PA.
Submitting Additional Information
Submitting Additional Information

1. Click the **Edit** button to edit a submitted PA request.

Additional information may include:
- Requests for additional services
- Attachments
- “FA-29 Prior Authorization Data Correction” form
- “FA-29A Request for Termination of Service” form
2. Add additional diagnosis codes, service details and/or attachments.
3. Click the **Resubmit** button to review the PA information.
4. Review the information.
5. Click the **Confirm** button.

NOTE: The PA number remains the same as the original PA request when resubmitting the PA request.
How to Submit Additional Information, continued

- Locate necessary forms on the Forms Page after the completion of a PA.
- Once the new information has been added to the PA request, click “Resubmit” to review the PA information.
- Click “Confirm” to resubmit the PA.
- The ATN will remain the same.

PA requests with a status of Not Certified or Cancel cannot be resubmitted. The Edit button will not appear on the View Authorization Response page.
Options if a PA is not approved
Denied Prior Authorization

If a prior authorization is denied by Nevada Medicaid, the provider has the following options:

• Request for a peer-to-peer review (avenue used in order to clarify why the request was denied or approved with modifications).

• Submit a reconsideration request (avenue used when the provider has additional information that was not included in the original request).

• Request a Medicaid provider hearing.
Peer-to-Peer Review

- The intent of a peer-to-peer review is to clarify the reason the PA request was denied or approved but modified.
- This is a verbal discussion between the requesting clinician and the clinician that reviewed the request for medical necessity.
- The provider is responsible for having a licensed clinician who is knowledgeable about the case participate in the peer-to-peer review.
- Additional information is not allowed to be presented because all medical information must be in writing and attached to the case.
- Must be requested within 10 business days of the denial.
- Peer-to-peer reviews can be requested by emailing nvpeer_to_peer@dxc.com.
- Only available for denials related to the medical necessity of the service.
- A peer-to-peer review is not required prior to a reconsideration, but once a reconsideration is requested, a peer-to-peer review is no longer an option.
Reconsideration Request

- Reconsiderations can be uploaded via the Provider Web Portal by completing an FA-29B form and uploading to the “File Exchange” on the Provider Web Portal.
- Additional medical documentation is reviewed to support the medical necessity.
- The information is reviewed by a different clinician than reviewed the original documentation.
- A peer-to-peer review is not required prior to a reconsideration, but once a reconsideration is requested, a peer-to-peer review is no longer an option.
Reconsideration Request, continued

• A reconsideration must be requested within 30 calendar days from the date of the denial, except for Residential Treatment Center (RTC) services, which must be requested within 90 calendar days.

• The 30-day provider deadline for reconsideration is independent of the 10-day deadline for peer-to-peer review.

• Give a synopsis of the medical necessity not presented previously. Include only the medical records that support the issues identified in the synopsis. Voluminous documentation will not be reviewed. It is the provider’s responsibility to identify the pertinent information in the synopsis.

• Only available for denials related to the medical necessity of the service.
Medicaid Provider Hearing

- Review Chapter 3100 (Hearings) of the Medicaid Services Manual located on the DHCFP website for further information regarding the Hearing Process.
Medicaid Billing Information
Locating Medicaid Billing Information

• Step 1: Highlight **Providers** from top blue tool bar.

• Step 2: Select **Billing Information** from the drop-down menu.
Locating Medicaid Billing Information, continued

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

<table>
<thead>
<tr>
<th>Title</th>
<th>File Size</th>
<th>Last Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Billing Manual</td>
<td>1 MB</td>
<td>02/01/2019</td>
</tr>
</tbody>
</table>

Review the Billing Manual for more information regarding:
- Introduction to Medicaid
- Contact Information
- Recipient Eligibility
- PA
- Third Party Liability (TPL)
- Electronic Billing
- Frequently Asked Questions
- Claims Processing and Beyond
Locating Medicaid Billing Information, continued

- Locate the section header “Billing Guidelines (by Provider Type)”
- Select appropriate provider type guideline
Fee Schedule and Rates Unit
Utilize the Search Fee Schedule to determine the Rate of Reimbursement for a procedure code.
Fee Schedule, continued

- Step 1: Check “I Accept” checkbox.
- Step 2: Click “Submit” button.
Fee Schedule, continued

- Step 1: Select Code Type from drop-down menu.
- Step 2: Input Procedure Code or Description.
- Step 3: Select Service Category from drop-down menu.
- Step 4: Click “Search” to populate results.
Fee Schedule, continued

- Note: Make sure that the “Effective Date” ends in 9999 for current rates of reimbursement

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**Search Fee Schedule**

- Indicates a required field.
- Select a code type, then enter the procedure code or description and provider type.
- This page is used only for Nevada Fee For Service (FFS) rates.
- The fee displayed to the user as a result of the search may not be the amount the provider receives; Information on the claim may affect actual fee amount. The information contained in the schedule is made available to provide information and is not a guarantee by the State or the Department or its employees as to the present accuracy of the information contained herein. For example, coverage as well as an actual rate may have been revised or updated and may no longer be the same as posted on the website.
- Revenue code pricing for inpatient and nursing home provider types 011, 013, 019, 051, 055, 063, 065, 075, and 078 that is specific to a provider is not available through the Fee Schedule. Provider specific rates override the fee schedule. In addition, fees are not currently available for PT 054.
- Modifier and specialty do not affect ASC and ESRD bundled rates, so the modifier and specialty will not be used or displayed in the search results for these rates.

**Nevada Medicaid Title XIX Fee For Service**

**Financial Payer and Benefit**

- Code Type: Medical
- Procedure Code or Description: 97010-Hot or cold packs therapy
- Provider Type: O34-Therapy
- Modifier: 034-Therapy
- Provider Specialty: 034-Therapy

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**Search Results**

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Provider Type</th>
<th>Provider Specialty</th>
<th>Modifier</th>
<th>Fee Amount</th>
<th>Age Restrictions</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>97010-Hot or cold packs therapy</td>
<td>O34-Therapy</td>
<td>000-No Specialty</td>
<td>22-Unusual Procedural Servic</td>
<td>$4.87</td>
<td>REGULAR</td>
<td>1/1/2017 - 12/31/2017</td>
</tr>
<tr>
<td>97010-Hot or cold packs therapy</td>
<td>O34-Therapy</td>
<td>000-No Specialty</td>
<td>22-Unusual Procedural Servic</td>
<td>$6.09</td>
<td>REGULAR</td>
<td>1/1/2017 - 12/31/2017</td>
</tr>
<tr>
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<td>O34-Therapy</td>
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<td>22-Unusual Procedural Servic</td>
<td>$6.77</td>
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<tr>
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<td>O34-Therapy</td>
<td>000-No Specialty</td>
<td>22-Unusual Procedural Servic</td>
<td>$5.95</td>
<td>Pediatric (age 0-21)</td>
<td>9/7/2008</td>
</tr>
<tr>
<td>97010-Hot or cold packs therapy</td>
<td>O34-Therapy</td>
<td>000-No Specialty</td>
<td>22-Unusual Procedural Servic</td>
<td>$3.38</td>
<td>REGULAR</td>
<td>1/1/2017 - 12/31/2017</td>
</tr>
<tr>
<td>97010-Hot or cold packs therapy</td>
<td>O34-Therapy</td>
<td>000-No Specialty</td>
<td>22-Unusual Procedural Servic</td>
<td>$4.22</td>
<td>REGULAR</td>
<td>1/1/1980 - 12/31/2016</td>
</tr>
</tbody>
</table>

---

Nevada Medicaid Therapy Provider Training
DHCFP Rates Unit

- Step 1: Highlight **Quick Links** from tool bar at www.medicaid.nv.gov.
- Step 2: Select **Rates Unit**.
- Step 3: From new window, select **Accept**.
DHCFP Rates Unit, continued

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

FEE SCHEDULES

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

- Provider Type 34 Therapy

- Select the appropriate title to open the PDF pertaining to the reimbursement schedule.
Submitting a Professional Claim via the EVS Secure Web Portal (DDE)
Understanding Claim Sub Menus
Understanding Claims Sub Menus

1. Hover over Claims.
2. Select the appropriate sub menu from the options.
Understanding Claims Sub Menus, continued

The page will display a list of Claims activities for the user to choose from.
Submitting a Professional Claim
Submitting a Claim

The Professional Claim submission process is broken out into three main steps:

- **Step 1** - Provider, Patient, and Claim Information plus an option to add Other Insurance details
- **Step 2** - Diagnosis Codes
- **Step 3** - Service Details and Attachments
1. Hover over the **Claims** tab.
2. Select **Submit Claim Prof.**
Submitting a Claim: Step 1

“Submit Professional Claim: Step 1” page sub-sections to complete:

A. Provider Information
B. Patient Information
C. Claim Information
3. Select the appropriate provider type/service location being billed from the **Billing Provider Service Location** drop-down option.

4. Enter the Rendering ID and ID Type. If the Rendering ID is unknown, click the button adjacent to the **Rendering Provider ID** field.

NOTE: If the Billing Provider has multiple locations, the user will use the drop-down option to locate and select the correct location for the claim.
Submitting a Claim: Step 1, continued

Provider Information

5. Select the desired search method.
6. Enter the provider’s last name.
7. Click the Search button, and the search results populate at the bottom.
8. Click the blue link in the Provider ID column with correct Provider ID.

NOTE: The user can also search by the Search By ID or Search By Organization tabs.
Submitting a Claim: Step 1, continued

Provider Information

9. Select a Rendering Provider Service Location from the drop-down.

NOTE: If needed, the user may enter a Referring Provider, Supervising Provider, or Service Facility Location ID the same way the Rendering Provider ID was entered.
Submitting a Claim: Step 1, continued

Patient Information

<table>
<thead>
<tr>
<th>Service Facility Location ID</th>
<th>ID Type</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Recipient ID**: 67770816236

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>TRNXEUUK</td>
<td>UGNWLA</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Birth Date</th>
<th>02/11/1985</th>
</tr>
</thead>
</table>

Claim Information

<table>
<thead>
<tr>
<th>Date Type</th>
<th>Date of Current</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Accident Related</th>
<th>Admission Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>*Patient Number</th>
<th>Authorization Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>*Transport Certification</th>
<th>*Does the provider have a signature on file?</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Yes&quot;</td>
<td>&quot;No&quot;</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Include Other Insurance</th>
<th>Total Charged Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Yes&quot;</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

10. Enter the 11-digit **Recipient ID** and click outside of the field to populate **Last Name**, **First Name** and **Birth Date**.
### Submitting a Claim: Step 1, continued

**Claim Information**

*NOTE: Other fields can be completed based on additional details known about the claim.*

<table>
<thead>
<tr>
<th>Data Type</th>
<th>Date of Current</th>
<th>Admission Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident Related</td>
<td>Date of Current</td>
<td>Admission Date</td>
</tr>
</tbody>
</table>

11. Enter the **Patient Number**.

12. Choose “Yes” or “No” to indicate a **Transport Certification**. (If “Yes,” additional details will be required. These are illustrated on the next slide.)
If the user selects “Yes” in the Transport Certification field, additional details must be entered.

13. Choose “Yes” or “No” as the Certification Condition Indicator.

14. Indicate the patient’s condition from the Condition Indicator drop-downs (up to five options may be selected).

15. Enter the distance (in miles) that the patient traveled into the Transport Distance field.

16. Select the Ambulance Transport Reason.
17. Indicate whether the provider has a signature on file.
18. Click the **Continue** button.
Submitting a Claim: Step 2

Diagnosis Codes

Once the user clicks the **Continue** button, the “Submit Professional Claim: Step 2” page is displayed with all the panels expanded.
Submitting a Claim: Step 2, continued

Diagnosis Codes

1. Choose a **Diagnosis Type**.
2. Enter the **Diagnosis Code**.
3. Click the **Add** button.

**NOTE:** The **Diagnosis Code** field contains a predictive search feature using the first three characters of the code or code description.
Submitting a Claim: Step 2, continued

Diagnosis Codes

Click the Remove link to remove a diagnosis code from the claim.

Once all the diagnosis codes have been entered, the user will:

4. Click the Continue button
Submitting a Claim: Step 3

Service Details

<table>
<thead>
<tr>
<th>Service Details</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Submit Professional Claim Step 3</strong></td>
<td>![Image of claim form]</td>
</tr>
<tr>
<td><strong>Provider Information</strong></td>
<td>![Image of claim form]</td>
</tr>
<tr>
<td><strong>Recipient ID</strong></td>
<td>G7770814226</td>
</tr>
<tr>
<td><strong>Recipient</strong></td>
<td>USAWLA TRAVERSE</td>
</tr>
<tr>
<td><strong>Birth Date</strong></td>
<td>02/15/1985</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td>Male</td>
</tr>
<tr>
<td><strong>Total Charged Amount</strong></td>
<td>$0.00</td>
</tr>
<tr>
<td><strong>Diagnosis Codes</strong></td>
<td>![Image of claim form]</td>
</tr>
<tr>
<td><strong>Service Details</strong></td>
<td>![Image of claim form]</td>
</tr>
</tbody>
</table>

Enter the following service details for the claim:

1. Enter the **From Date** and **To Date** that services were rendered.
2. Select the **Place of Service** from the drop-down.
3. Enter the **Procedure Code**, which is searchable by entering at least the first three letters or numbers of the code description.

4. Enter at least one **Diagnosis Pointer**.

**NOTE:** **Diagnosis Pointers** are used to show what diagnosis is applicable to a service detail.
Submitting a Claim: Step 3

Service Details

With the **Procedure Code** and **Diagnosis Pointers** entered, the user will need to:

5. Enter a **Charge Amount**.
6. Enter the number of **Units**.
7. Select a **Unit Type** from the drop-down.
8. Click the **Add** button to add the procedure to the claim.

NOTE: The user may enter any additional details, such as **Modifiers**, prior to clicking **Add**. Repeat Steps 1-8 in this section for each additional procedure.
Submitting a Claim: Step 3, continued

Service Details

When editing a Service Detail, three buttons are available:

**Save**: Saves any changes made to the detail.

**Reset**: Clears all fields in the selected service detail.

**Cancel**: Cancels any updates and closes the service detail.
Submitting a Claim: Step 3, continued

9. Click the **Submit** button.
10. Click the **Confirm** button.
Submitting a Claim: Step 3, continued

The Submit Professional 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.
- 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 Professional Claim: Attachments
Submitting a Claim: Attachments

To upload attachments to a professional claim:

1. Click the (+) sign on the Attachments panel.
2. Click **Browse** button and locate the file on your computer to be attached. A window will then pop up. From there:

3. Locate and select the file.

4. Click the **Open** button.

**NOTE:** The **Transmission Method** field will populate with “FT - File Transfer” by default and does not need to be changed.
5. Select the type of attachment from the **Attachment Type** drop-down list.

6. Click the **Add** button to attach the file OR click on the **Cancel** button to cancel and close the attachment line.

**NOTE:** A description of the attachment may be entered into the **Description** field, but it is not required.
Submitting a Claim: Attachments, continued

7. Click the **Submit** button to proceed.

NOTE: To remove any attachments, click the **Remove** link.
Submitting a Professional Claim: Other Insurance Details
1. Check the **Include Other Insurance** checkbox located at the bottom of the page.
2. Click the **Continue** button.
To add a policy or other insurance carrier information:

3. Click (+) in the Other Insurance Details panel at the bottom of the page.
Submitting a Claim: Other Insurance Details, continued

4. The user must enter all required fields.
5. 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 or other health insurance details.
After the user clicks the Add Insurance button, the new insurance will populate at the bottom of the list of carriers.

### 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.

<table>
<thead>
<tr>
<th>#</th>
<th>Carrier Name</th>
<th>Carrier ID</th>
<th>Policy ID</th>
<th>Payer Paid Amount</th>
<th>Paid Date</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>HEALTH PLAN OF NEVADA</td>
<td>07762</td>
<td>05060442803</td>
<td></td>
<td></td>
<td>Remove</td>
</tr>
<tr>
<td>2</td>
<td>HEALTH PLAN OF NEVADA</td>
<td>07549</td>
<td>0299604428-99</td>
<td></td>
<td></td>
<td>Remove</td>
</tr>
<tr>
<td>3</td>
<td>Insurance Plan</td>
<td>120456789</td>
<td>987654321</td>
<td>08/01/2018</td>
<td></td>
<td>Remove</td>
</tr>
</tbody>
</table>

Click to add a new other insurance.
To update existing other insurance carrier information, the user will:

1. Select the sequence number of any other insurance line item.
2. Update the payment and liability details.
3. Select a Claim Filing Indicator from the drop-down list.

NOTE: Click the Remove link to remove any other insurance details unrelated to the claim.
Submitting a Claim: Other Insurance Details, continued

To add an adjustment:

4. Enter the details of the adjustment.
5. Click the **Add Adjustment** button to add claim adjustment details.
6. Click the **Save Insurance** button to save the information to the other insurance details line OR click the **Cancel Insurance** button to cancel all changes.
Submitting a Claim: Other Insurance Details, continued

Continue to Step 3 of the claim submission process:

7. Click the Continue button.
Submitting a Crossover Professional Claim
Submitting a Crossover Claim

1. Select the Claim Type: Crossover Professional.

NOTE: The user will follow the same steps as previously shown in the “Submitting a Professional Claim” section.
Submitting a Crossover Claim, continued

2. Enter the Medicare Crossover Details:
   - Allowed Medicare Amount
   - Deductible Amount
   - Medicare Payment Amount
   - Medicare Payment Date

3. Click the Continue button.
Submitting a Crossover Claim, continued

4. Enter applicable service detail information. Required fields are marked with a red asterisk (*).
5. Click the Add button.
Submitting a Crossover Claim, continued

6. Click the **Submit** button.
Submitting a Crossover Claim, continued

7. Click the **Confirm** button.

<table>
<thead>
<tr>
<th>Medicare Crossover Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Allowed Medicare Amount</strong></td>
</tr>
<tr>
<td><strong>Deductible Amount</strong></td>
</tr>
<tr>
<td><strong>Medicare Payment Amount</strong></td>
</tr>
<tr>
<td><strong>Co-insurance Amount</strong></td>
</tr>
<tr>
<td><strong>Psychiatric Services Amount</strong></td>
</tr>
<tr>
<td><strong>Medicare Payment Date</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Place of Service</strong></td>
</tr>
<tr>
<td><strong>Procedure Code</strong></td>
</tr>
<tr>
<td><strong>Diag Code Pts</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>From Date</strong></td>
</tr>
<tr>
<td><strong>To Date</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>No Other Insurance Details exist for this claim</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>No Attachments exist for this claim</th>
</tr>
</thead>
</table>
Submitting a Crossover Claim, continued

The user will receive a **Confirmation** with the **Professional Claim Receipt**.

![Confirmation Image]

- The claim status is Finalized Payment.
- The Claim ID is 22189297000010.
Searching for a Professional Claim
Searching for a Claim

To search for a claim the user will need to:

1. Hover over **Claims**.
2. Select **Search Claims**.
Searching for a Claim, continued

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

To search without using the Claim ID:
3. Enter the search parameters.
4. Click the Search button.

NOTE: When searching for a claim without using the Claim ID, the user must enter the Recipient ID along with the Service From and To date range as shown in this example.
Searching for a Claim, continued

Once the user has clicked the Search button, the results will display below. From there, the user may:

5. Click the (+) symbol to expand the claim details.
Searching for a Claim, continued

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

<table>
<thead>
<tr>
<th>Claim ID</th>
<th>TCN</th>
<th>Claim Type</th>
<th>Claim Status</th>
<th>Service Date</th>
<th>Recipient ID</th>
<th>Rendering Provider ID</th>
<th>Medicaid Paid Amount</th>
<th>Paid Date</th>
<th>Recipient Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>2218256000002</td>
<td></td>
<td>Professional</td>
<td>Finalized Denied</td>
<td>09/12/2018</td>
<td>67770816236</td>
<td>1003195538</td>
<td>$0.00</td>
<td>09/14/2018</td>
<td></td>
</tr>
</tbody>
</table>

### Professional Claim Information

- **Recipient**: UGNWLA TRNXEUK
- **Birth Date**: 02/11/1965
- **Rendering Provider**: MICHAEL A SMITH
- **Claim Status**: Finalized Denied

- **Total Charge Amount**: $300.00
- **Total Paid Amount**: $0.00
- **Paid Date**: 09/14/2018
- **Reason Code**: Finalized/Denial-The claim/line has been denied.

### Service Information

<table>
<thead>
<tr>
<th>Service</th>
<th>Service Date</th>
<th>Line Status</th>
<th>Reason Code</th>
<th>Units</th>
<th>Procedure/Modifiers</th>
<th>Charge</th>
<th>Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>09/12/2018</td>
<td>Finalized Denied</td>
<td>Finalized/Denial-The claim/line has been denied.</td>
<td>1</td>
<td>2018F</td>
<td>$100.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>2</td>
<td>01/12/2018</td>
<td>Finalized Denied</td>
<td>Finalized/Denial-The claim/line has been denied.</td>
<td>1</td>
<td>06361</td>
<td>$200.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

6. Click the **blue Claim ID link** to open a specific claim.

NOTE: The user may view the RA by clicking the **RA Copy (PDF)** button. Searching for RAs will be covered later in the training.
If the claim is denied, the user may review the errors as follows:

7. Click the (+) symbol adjacent to the **Adjudication Errors** panel.
Searching for a Claim, continued

With the **Adjudication Errors** panel expanded, the user may review the errors associated with the claim’s denial.

NOTE: User will be shown how to adjust a claim later in this training.
Viewing Professional Claim Remittance Advice (RA)
Viewing a Claim’s RA

To begin locating an RA, the user will:

1. Hover over **Claims**.
2. Select **Search Payment History**.
3. Enter search criteria to refine the search results.
4. Click the **Search** button.

NOTE: Users can only search for RAs on the Provider Web Portal for the past 6 months. The default search range is for the past 90 days.
5. Click on the RA Copy (PDF) icon.

### Viewing a Claim’s RA, continued

<table>
<thead>
<tr>
<th>Issue Date</th>
<th>Payment Method</th>
<th>Payment Type</th>
<th>Check # / RA #</th>
<th>Total Paid Amount</th>
<th>RA Copy (PDF)</th>
</tr>
</thead>
<tbody>
<tr>
<td>09/14/2018</td>
<td>CHK</td>
<td>C</td>
<td>000000000/100005447</td>
<td>$0.00</td>
<td></td>
</tr>
<tr>
<td>09/07/2018</td>
<td>CHK</td>
<td>C</td>
<td>000012397/100005394</td>
<td>$30.00</td>
<td></td>
</tr>
<tr>
<td>09/07/2018</td>
<td>ACH</td>
<td>E</td>
<td>00930866/100005351</td>
<td>$130.00</td>
<td></td>
</tr>
<tr>
<td>08/31/2018</td>
<td>CHK</td>
<td>C</td>
<td>000000000/100005323</td>
<td>$0.00</td>
<td></td>
</tr>
<tr>
<td>08/17/2018</td>
<td>CHK</td>
<td>C</td>
<td>000000000/100005263</td>
<td>$0.00</td>
<td></td>
</tr>
<tr>
<td>08/10/2018</td>
<td>ACH</td>
<td>E</td>
<td>00930835/100005216</td>
<td>$300.00</td>
<td></td>
</tr>
<tr>
<td>08/10/2018</td>
<td>ACH</td>
<td>E</td>
<td>00930819/100005155</td>
<td>$610.00</td>
<td></td>
</tr>
<tr>
<td>07/13/2018</td>
<td>ACH</td>
<td>E</td>
<td>00930502/100004980</td>
<td>$50.00</td>
<td></td>
</tr>
<tr>
<td>07/06/2018</td>
<td>ACH</td>
<td>E</td>
<td>00930797/100004951</td>
<td>$20.00</td>
<td></td>
</tr>
<tr>
<td>06/29/2018</td>
<td>ACH</td>
<td>E</td>
<td>00930789/100004925</td>
<td>$10.00</td>
<td></td>
</tr>
</tbody>
</table>
**Viewing a Claim’s RA, continued**

6. User will click the **Open** button.
After clicking Open, the user can review the RA.
Copying Professional Claims
Copying a Claim

To copy a claim, the user will:

1. Return to the “Search Claims” page.
2. Enter the search criteria.
3. Click the Search button.

Search results will populate at the bottom of the screen.

From the search results:

4. Click the blue Claim ID link.
After the user has viewed the claim, user will:

5. Scroll down to the bottom of the “Claim Information” page.
6. Click the **Copy** button.
7. Select what portion of the claim to copy (for this example, the user has selected **Entire Claim**).
8. Click the **Copy** button.
As the user goes through Steps 1-3, the user may make updates.

9. Click the **Continue** button.
Adjusting a Professional Claim
Adjusting a Claim

To begin the claim adjustment process:

1. Return to the “Search Claims” page.
2. Enter the search criteria.
3. Click the Search button.
4. Click the blue Claim ID link.

NOTE: Denied Claims cannot be adjusted. The Claim Status column will indicate “Finalized Payment” if a claim is paid.
Adjusting a Claim, continued

On the “View Professional Claim” page, the user will:

5. Scroll down to the bottom of the page.

6. Click the Adjust button.
From here, the user may:

7. Review and make any necessary edits to the provider, patient or claim information.

8. Review the **Adjudication Errors** panel to identify any issues that may need to be resolved.

9. Click on the **Continue** button at the bottom of the page to proceed to the next step.
10. Click the **Resubmit** button.

---

### Adjusting a Claim, continued

#### Nevada Medicaid Therapy Provider Training

<table>
<thead>
<tr>
<th>Service Date</th>
<th>From Date</th>
<th>To Date</th>
<th>Place of Service</th>
<th>Procedure Code</th>
<th>Charge Amount</th>
<th>Units</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>09/18/2018</td>
<td>09/18/2018</td>
<td>32-Nursing Facility</td>
<td>99001-Nursing Fac care admit</td>
<td>$175.00</td>
<td>1000 Unit</td>
<td></td>
</tr>
</tbody>
</table>

10. Click the **Resubmit** button.
11. Click the **Confirm** button.

**NOTE:** Click the **Cancel** button to cancel the adjustment.
The “Resubmit Professional Claim: Confirmation” page will appear after the claim has been submitted. It will display the claim status and adjusted Claim ID.
Submitting an Appeal for a Claim
Submitting an Appeal for a Claim

From the home page, the user will:

1. Select **Secure Correspondence** to start the Appeal process.
Submitting an Appeal for a Claim, continued

The user will then:

2. Select “Claims – Appeals” from the Message Category dropdown and fill out all of the required fields.
Submitting an Appeal for a Claim, continued

Next, the user will need to:

3. Click the **Browse** button and locate the file supporting the appeal request.

4. Click the **Send** button.

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.
Submitting an Appeal for a Claim, continued

After the user clicks the Send button, a confirmation message will populate with “Your secure message was successfully sent.”

User will then need to:
5. Click the OK button.
Submitting an Appeal for a Claim, continued

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

<table>
<thead>
<tr>
<th>Status</th>
<th>CTN #</th>
<th>Subject</th>
<th>Message Category</th>
<th>Date Opened</th>
<th>Last Activity Date</th>
</tr>
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<td>04/29/2018</td>
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</tbody>
</table>
Voiding a Professional Claim
Voiding a Claim

To search for a claim the user will need to:

1. Hover over **Claims**.
2. Select **Search Claims**.
3. Enter **Claim ID**.
4. Click the **Search** button.
Voiding a Claim, continued

Once the user has clicked the **Search** button, the results will display below.

To open the claim, the user will:

5. Click the **blue** Claim ID link to open the claim.

**NOTE:** Denied Claims cannot be voided. The **Claim Status** column will indicate “Finalized Payment” if a claim is paid.
To void the claim, the user will:

6. Click the **Void** button.
7. Click the **OK** button.
8. Click the OK button.
Resources
Additional Resources

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

DHCFP Contact Information:
Contact Form: http://dhcfp.nv.gov/Contact/ContactUsForm/
Contact Nevada Medicaid
Contact Nevada Medicaid

Prior Authorization Department: 800-525-2395

Customer Service Call Center: 877-638-3472 (Monday through Friday 8 am to 5 pm Pacific Time)

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