Durable Medical Equipment

Provider Type 33 Training

Nevada Medicaid Provider Training

2018

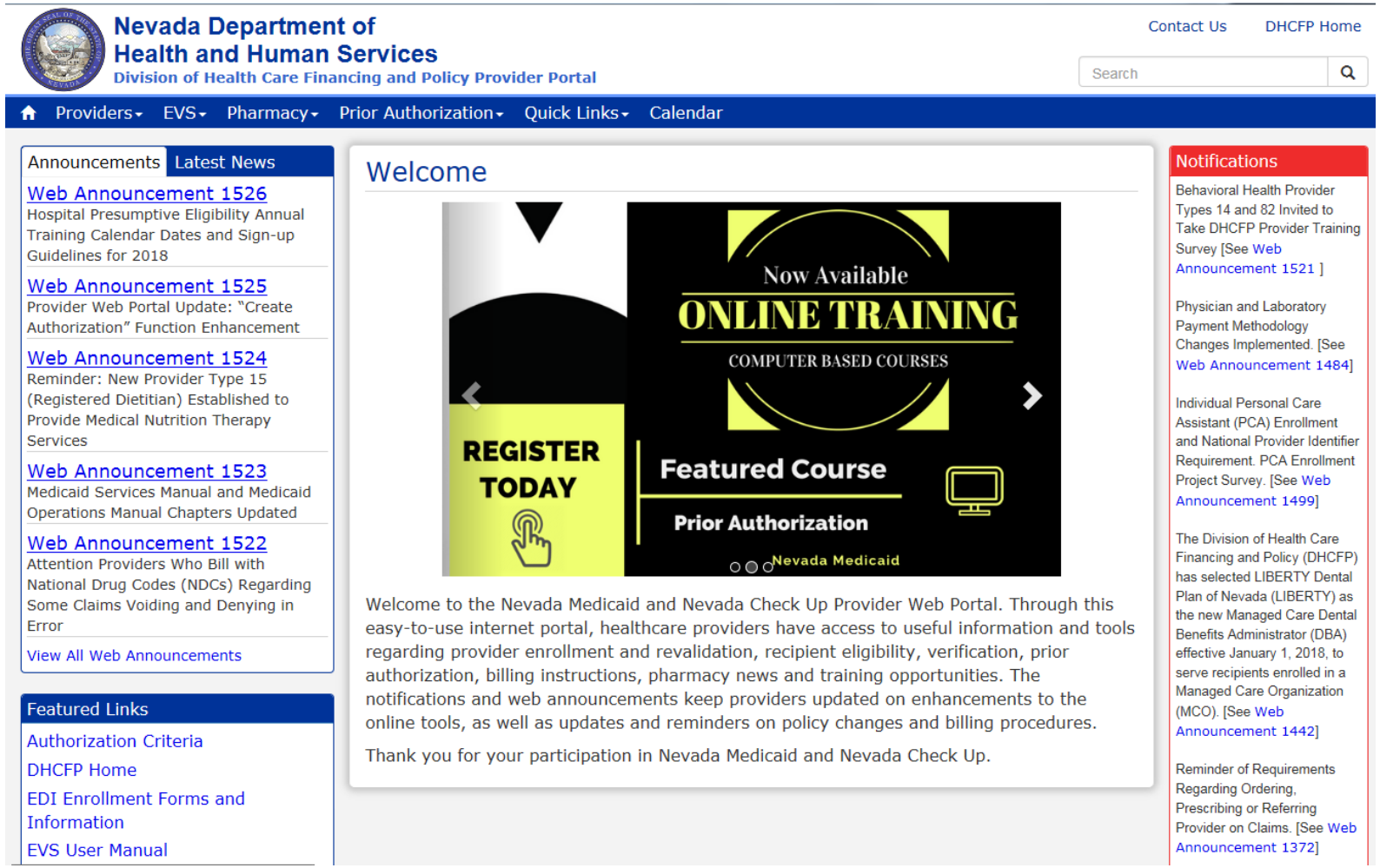
Objectives

Objectives

- Review Durable Medical Equipment (DME) Program Information
- Locate Medicaid Policy
- Locate Public Notice/Hearings Information
- Review Web Announcements
- Locate CMS-1500 Claim Form Instructions, Billing Manual and Billing Guidelines
- Utilize the Search Fee Schedule
- Use the Authorization Criteria
- Locate and Review Prior Authorization Forms
- Login to the Electronic Verification System (EVS) Secure Web Portal
- Review Delegate Access
- Utilize the Treatment History Function
- Successfully Submit a Prior Authorization
- View Prior Authorizations
- Learn about the Benefits of Electronic Data Interchange (EDI)
- Edit Codes and Resolutions

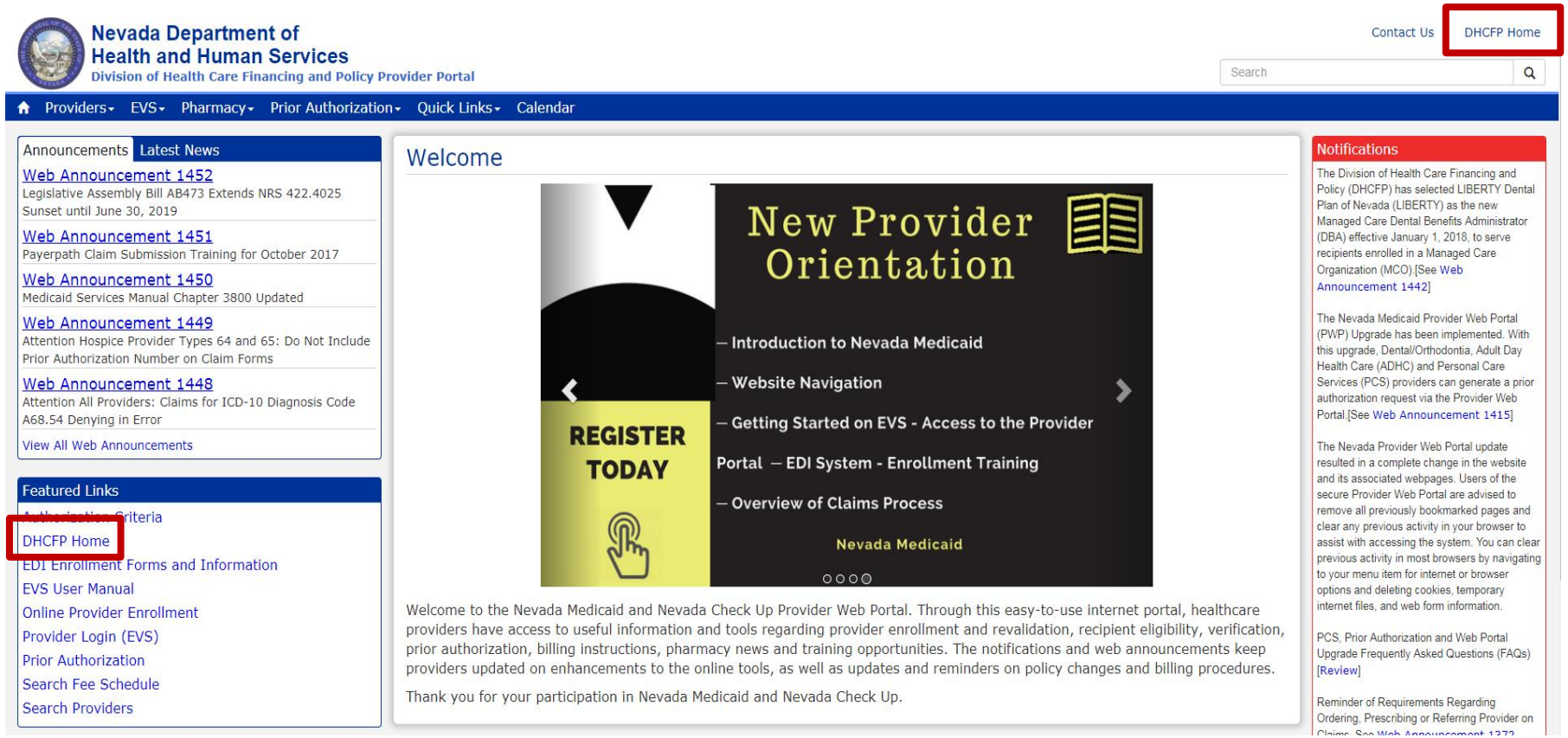
Provider Web Portal

Provider Web Portal
www.medicaid.nv.gov



Program Information

Locating Program Information



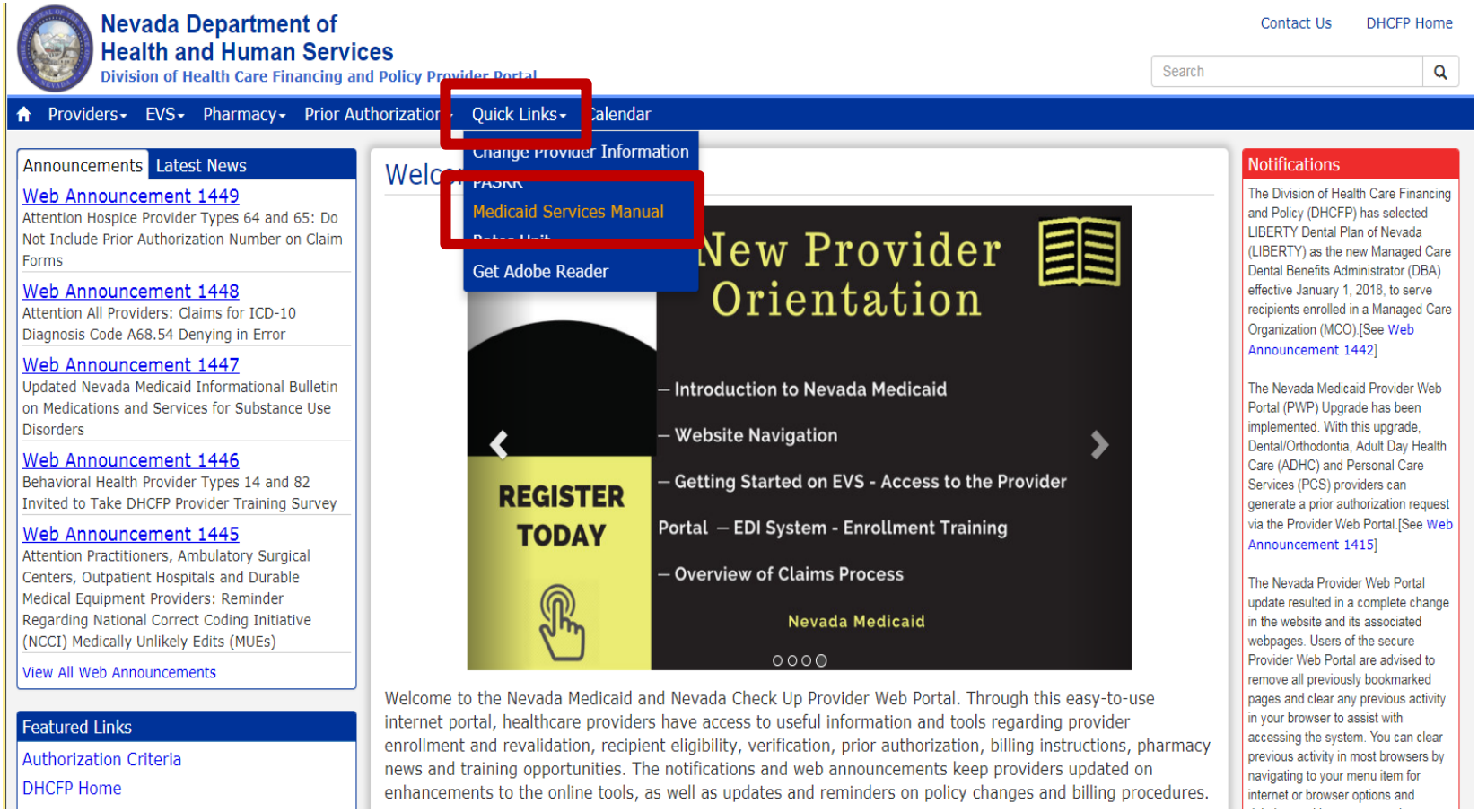
– Select “DHCFP Home” from the Featured Links or top right hand side of page

Locating Program Information, continued

– Highlight “Programs” and select “Durable Medical Equipment” from the sub-menu

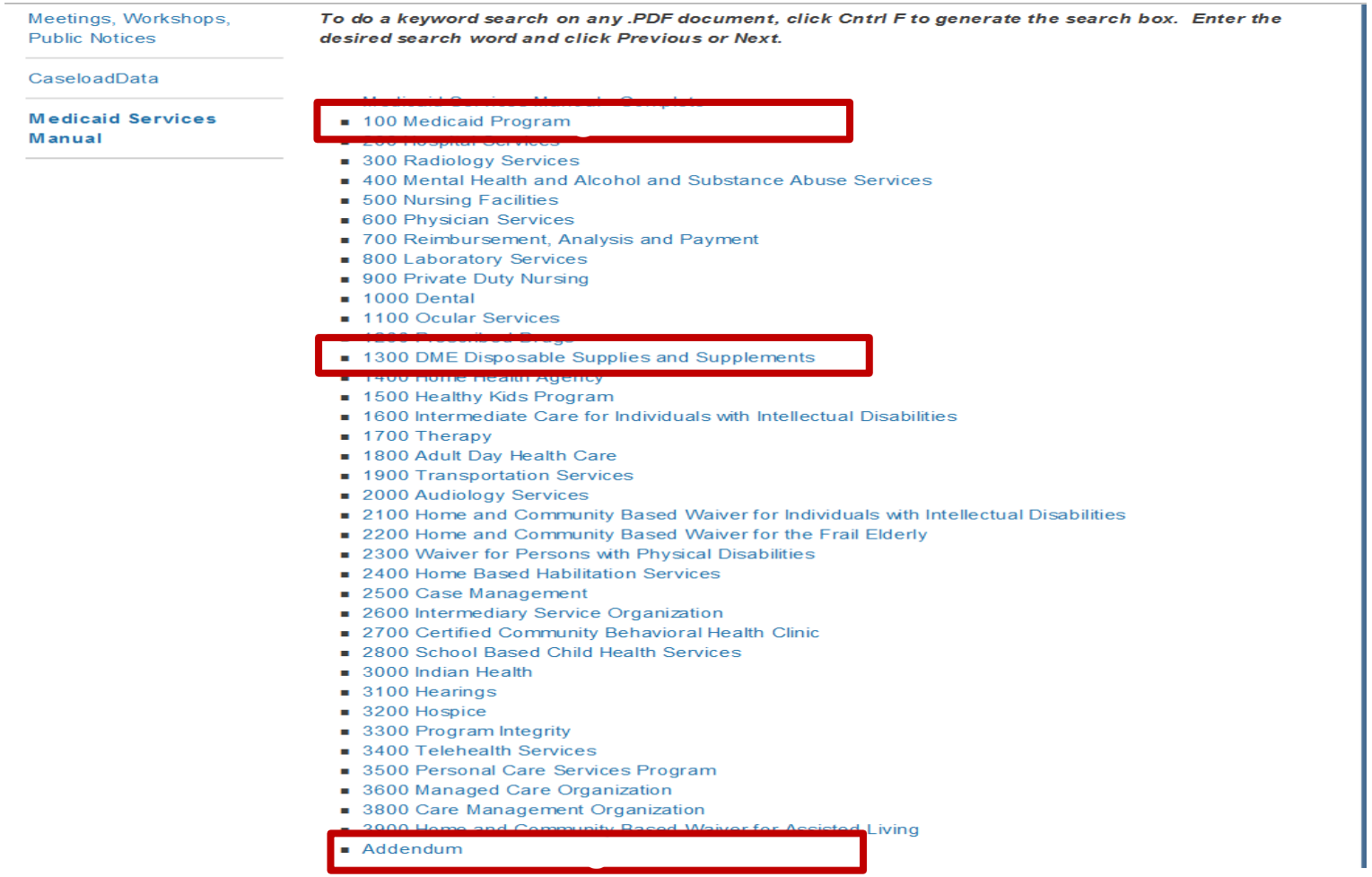
Medicaid Services Manual (MSM)

Locating the Medicaid Services Manual (MSM)



- Step 1: Highlight “Quick Links” from top blue tool bar
- Step 2: Select “Medicaid Services Manual” from the drop-down menu
- Note: MSM Chapters will open in new webpage through the DHCFP website

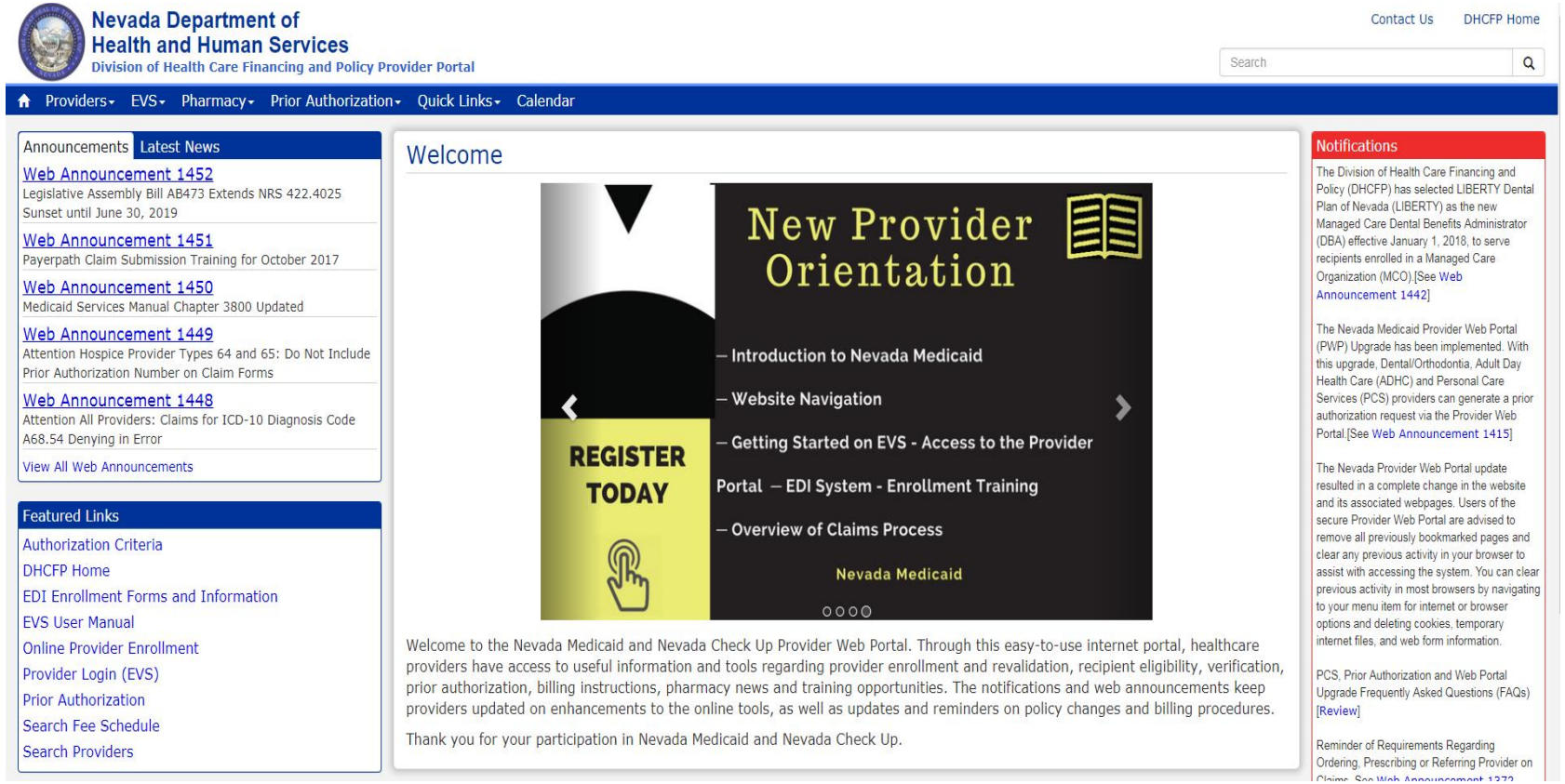
Locating MSM Chapter 1300



- Select “1300 DME Disposable Suppliers and Supplements”
- All providers are responsible for knowing the information in Chapter 100 “Medicaid Program” and the Addendum
- From the next page, always make sure to select the “Current” policy

Division of Health Care Financing and Policy (DHCFP) Public Notices

Locating Public Notice Information



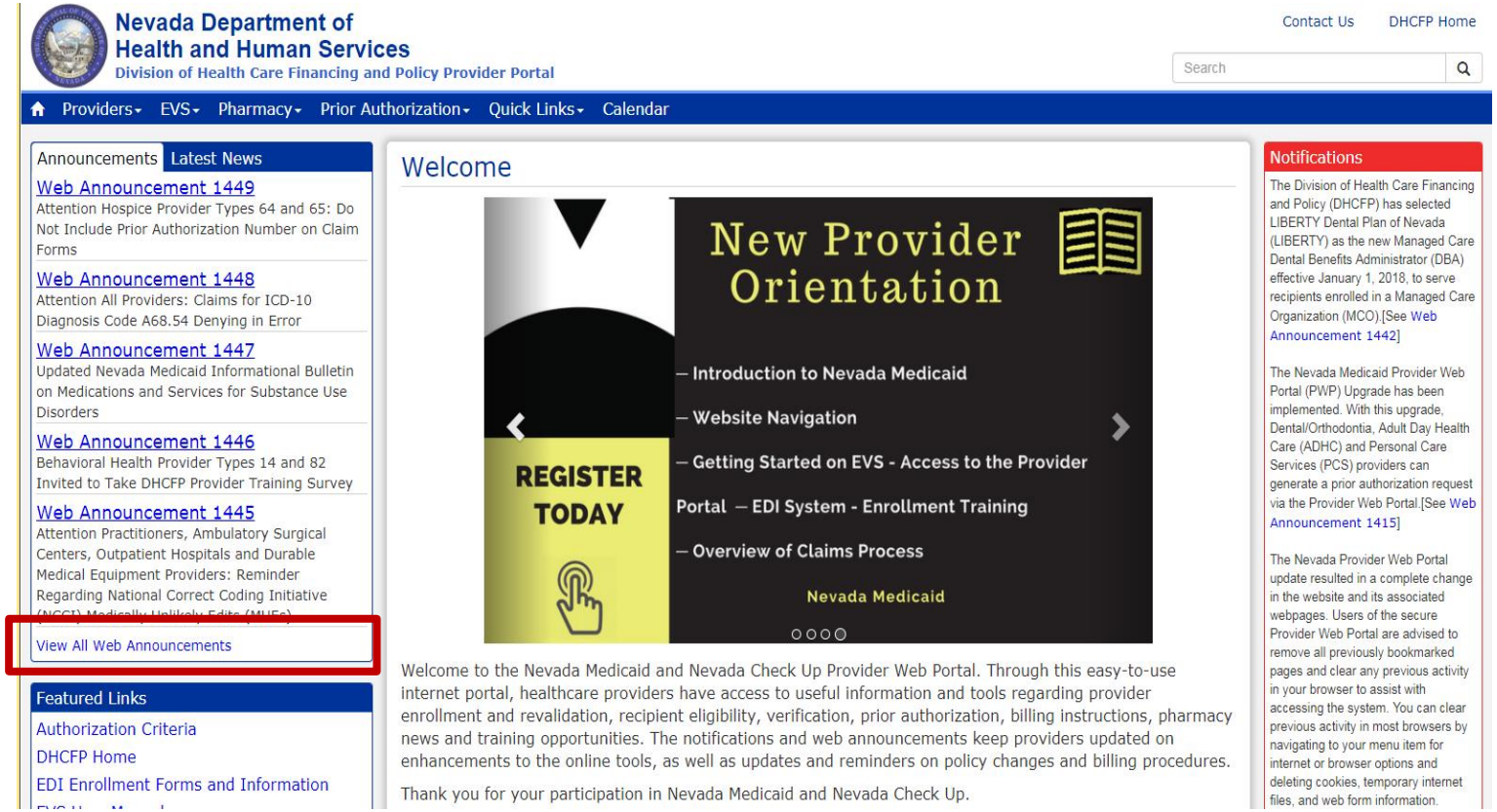
- Select “DHCFP Home” from the Featured Links or top right hand side of page

Locating Public Notice Information, continued

- From the “DHCFP Home” page highlight “Public Notices”
- Select “Meetings/Public Notices”
- The webpage that opens will provide information pertaining to upcoming meetings

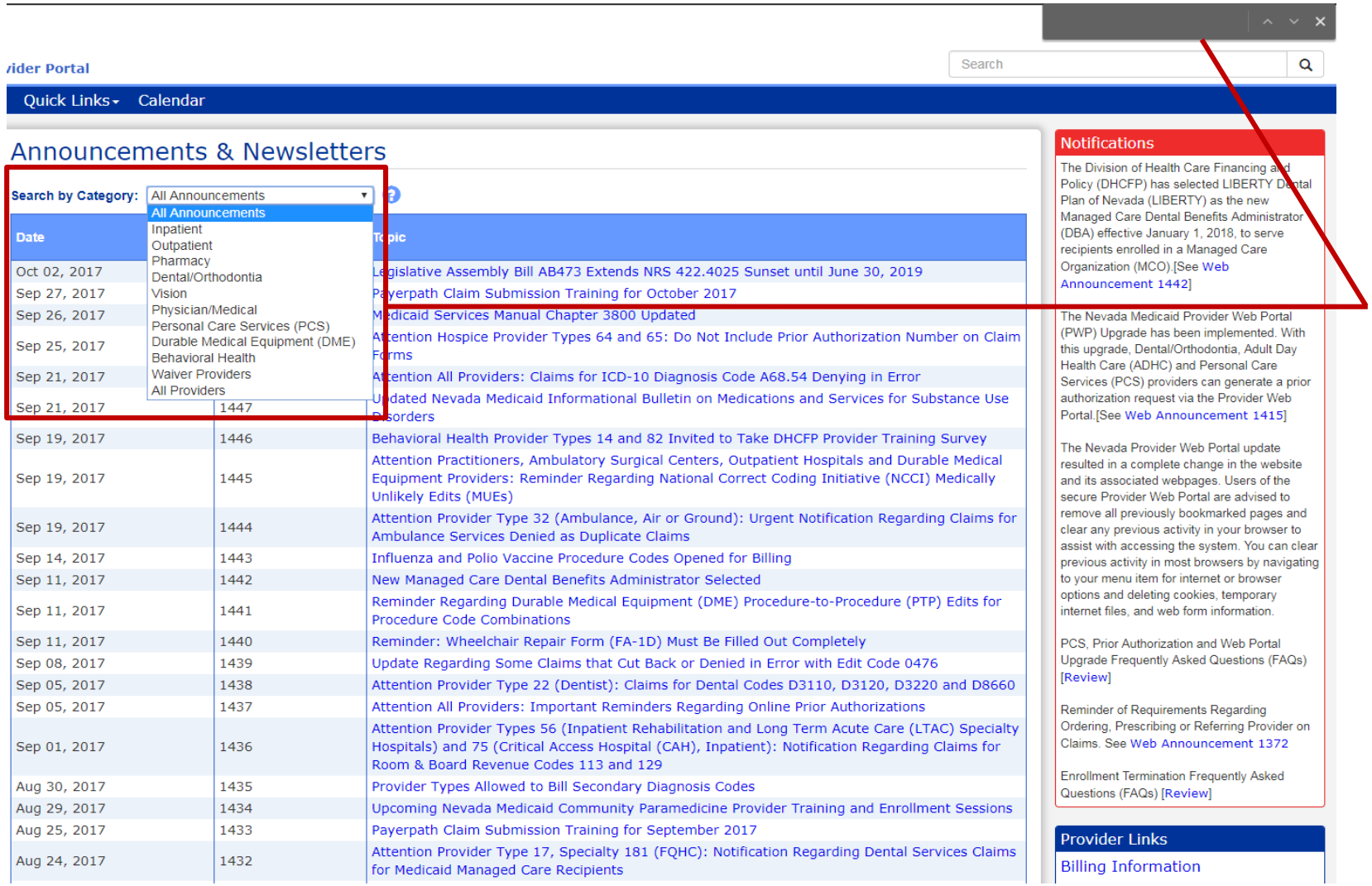
Viewing Web Announcements

Web Announcements



– Select “View All Web Announcements” to view Web Announcements

Web Announcements, continued



– Results can be narrowed selecting a category from the drop-down menu or utilizing the “Ctrl F” to bring up a Search Box

Web Announcements, continued

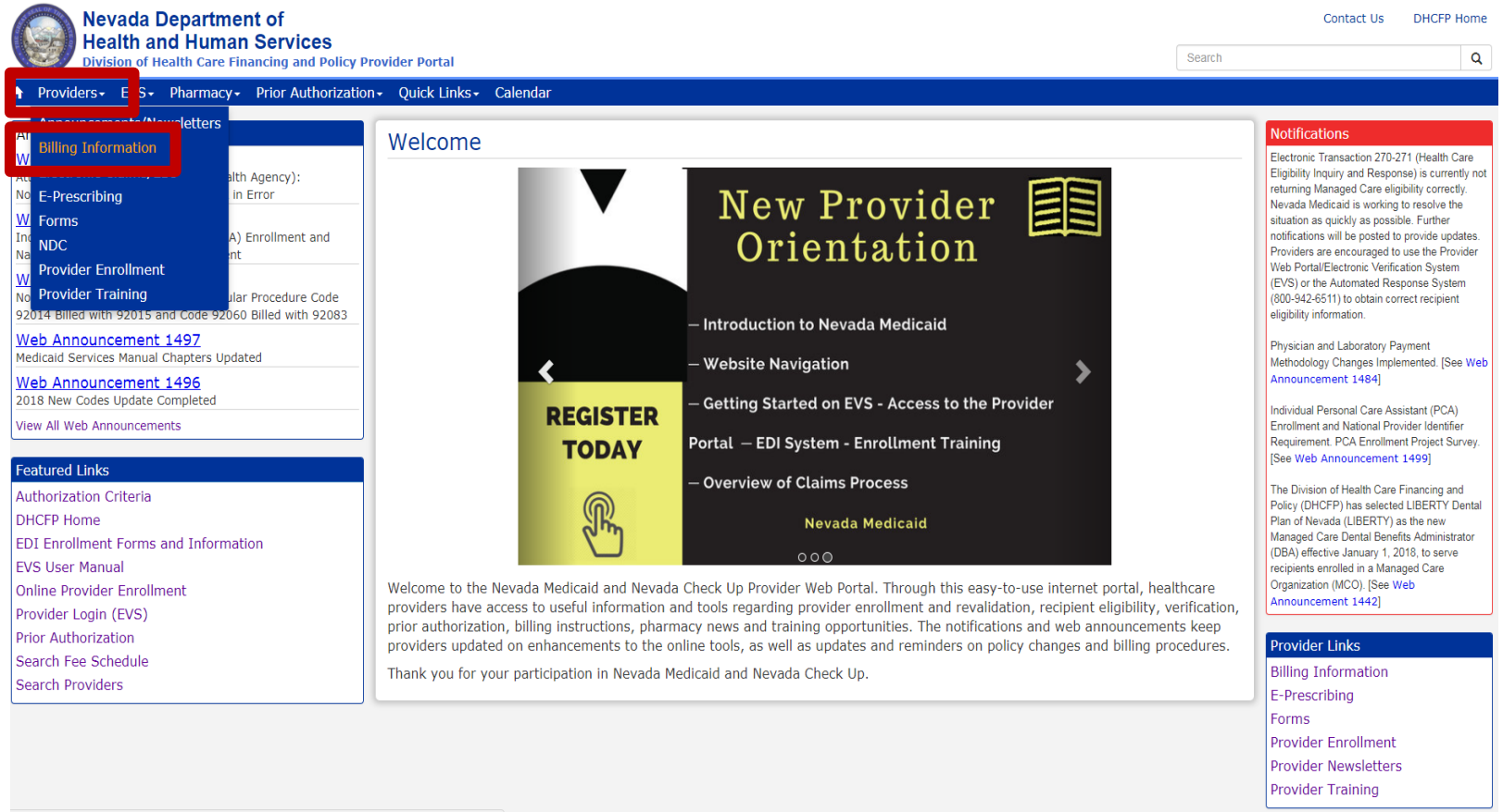
- **Web Announcement 1466** – Contains information regarding procedure code A5500 and possible denials of claims. Any claims submitted with a date of service between October 1, 2015, and November 6, 2017, that have denied with only edit code 0967 will be automatically reprocessed.

- **Web Announcement 1469** – Contains information that as of November 6, 2017, Healthcare Common Procedure Coding System (HCPCS) codes billed by DME providers have been updated. This includes codes that are no longer billable.

- **Web Announcement 1496** – Contains information regarding new rates and prior authorization requirements for 2018.

Medicaid Billing Information

Locating Medicaid Billing Information



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

Locating Medicaid Billing Information, continued

Paper Claim Form Instructions

Title	Last Update
ADA (Version 2012) Claim Form Instructions	01/28/16
CMS-1500 (02-12) Claim Form Instructions	07/27/17
UB Claim Form Instructions	05/30/17

Billing Manual

For Archives Click here

Title	File Size	Last Update
Billing Manual	2 MB	09/01/2017

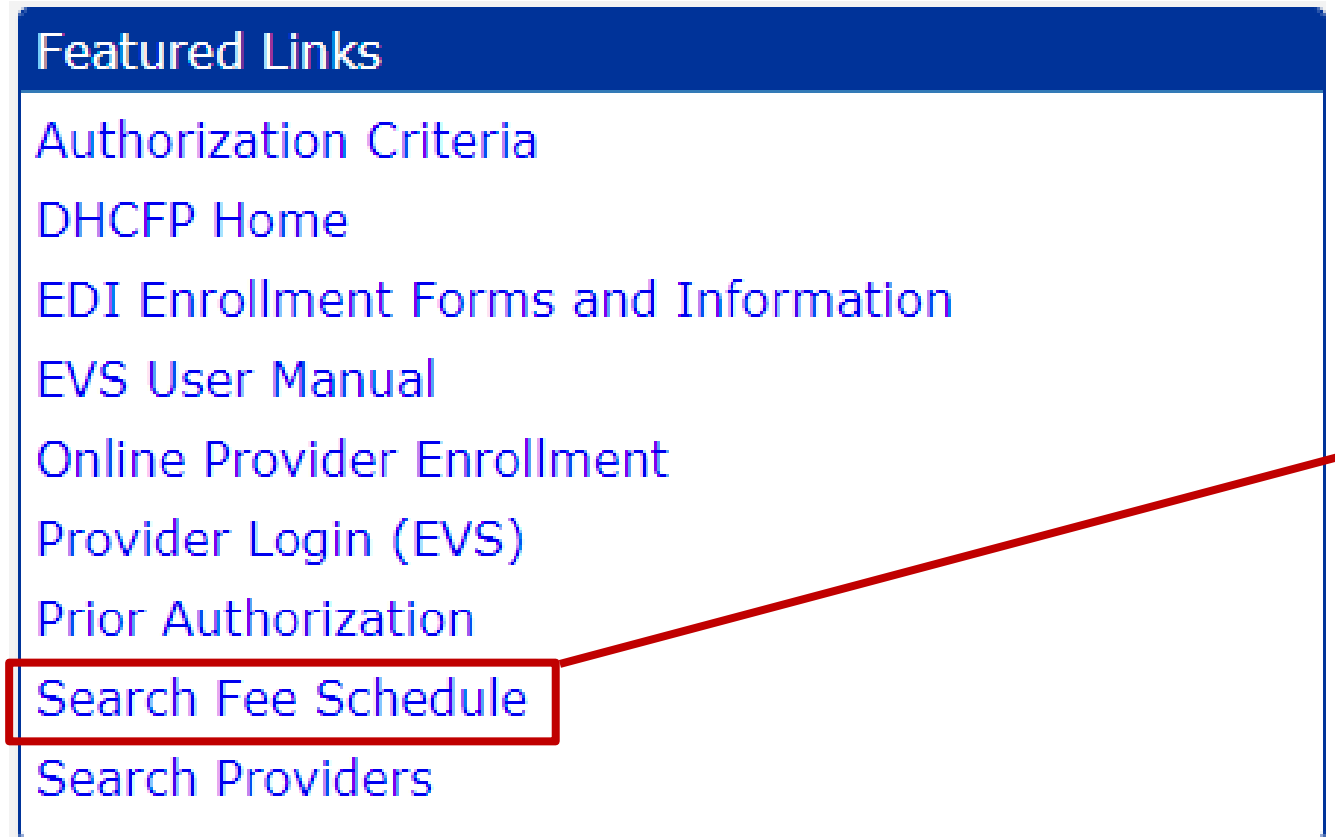
Billing Guidelines (by Provider Type)

33	Durable Medical Equipment (DME), Disposable, Prosthetics	07/24/17

- Utilize the CMS-1500 Claim Form Instructions to properly submit claims
- Utilize the Billing Manual for general billing information
- Utilize the Billing Guidelines for specific information for PT 33, including prior authorization information, and covered and non-covered services

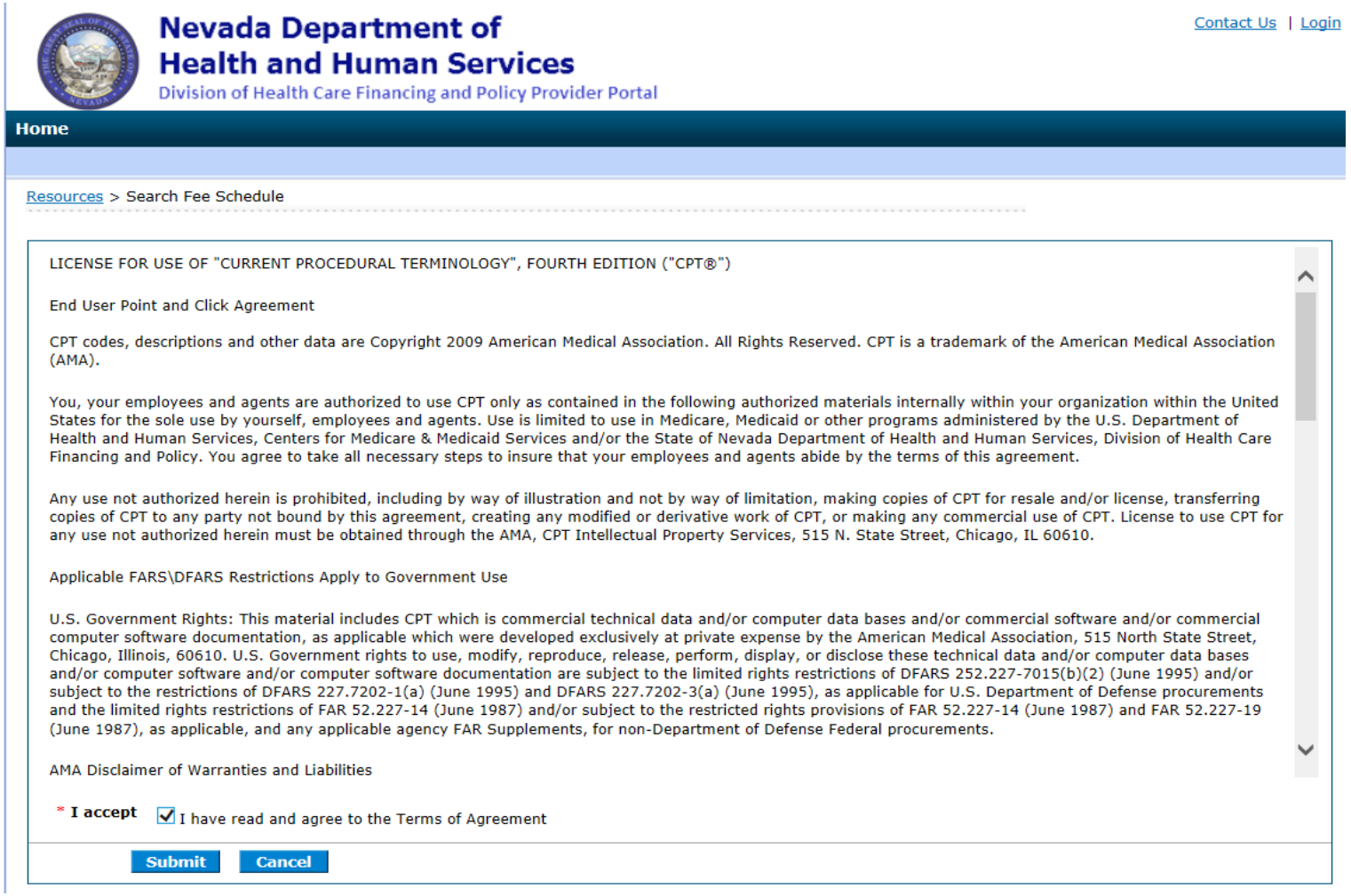
Fee Schedule and Rates Unit

Fee Schedule



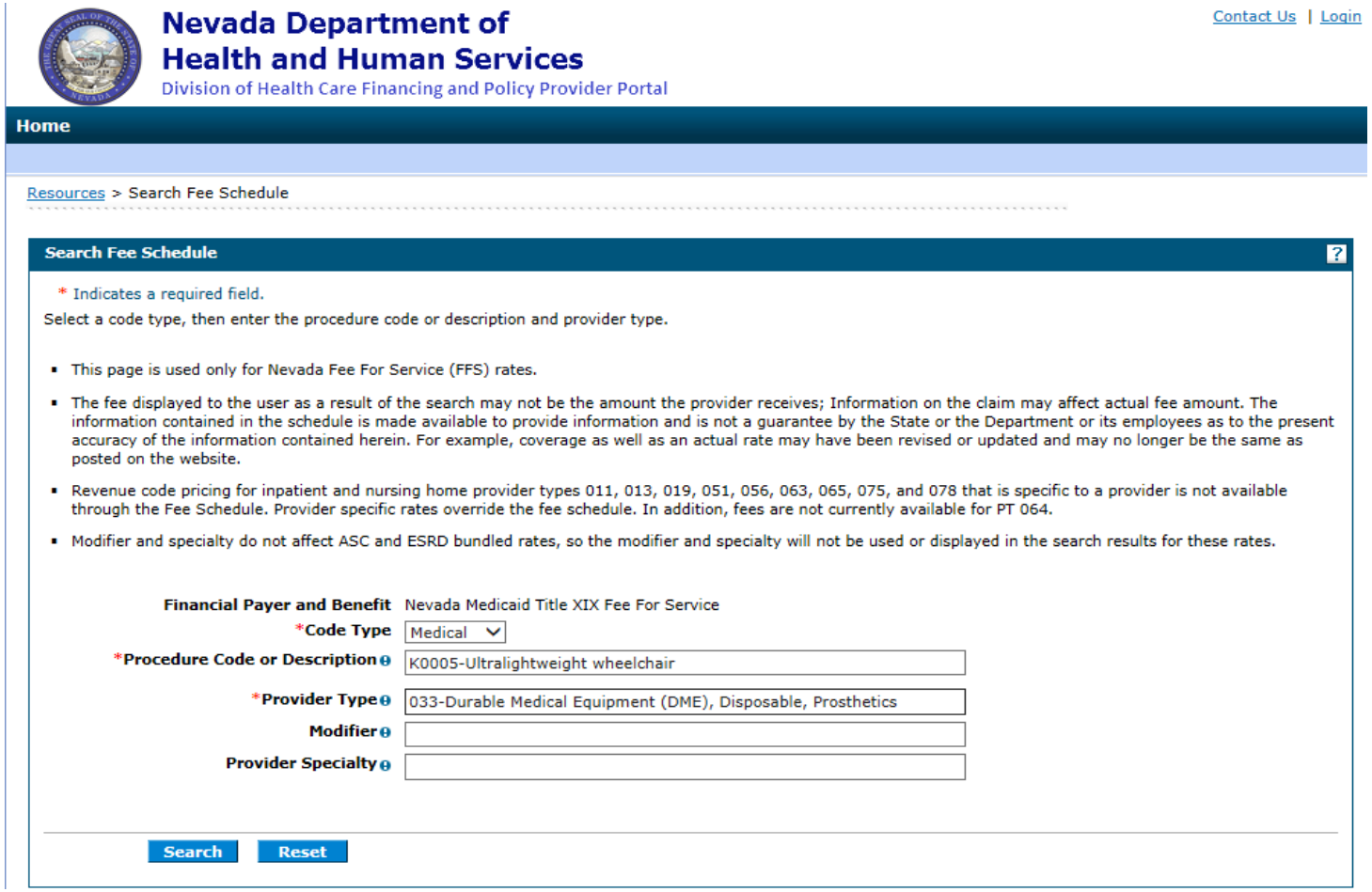
- Utilize the Search Fee Schedule to determine the rate of reimbursement for a procedure code

Fee Schedule, continued



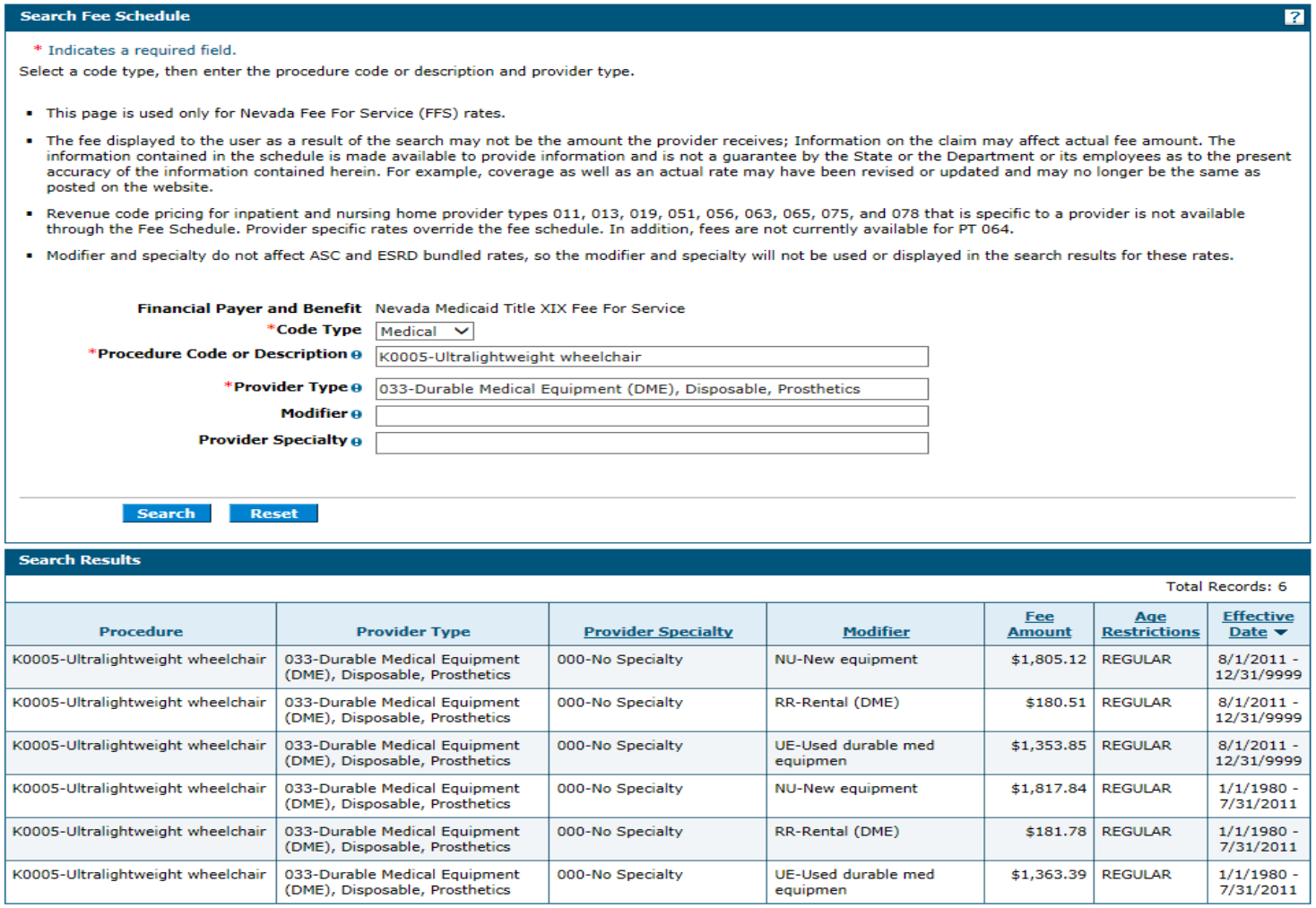
- Step 1: Click “I Accept”
- Step 2: Click “Submit”

Fee Schedule, continued



- Step 1: Select Code Type from the drop-down menu
- Step 2: Input Procedure Code of Description
- Step 3: Input appropriate Provider Type
- Step 4: Click “Search” to populate results

Fee Schedule, continued



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, 056, 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 064.
- 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.

Financial Payer and Benefit Nevada Medicaid Title XIX Fee For Service

***Code Type** Medical

***Procedure Code or Description** K0005-Ultralightweight wheelchair

***Provider Type** 033-Durable Medical Equipment (DME), Disposable, Prosthetics

Modifier

Provider Specialty

Search Reset

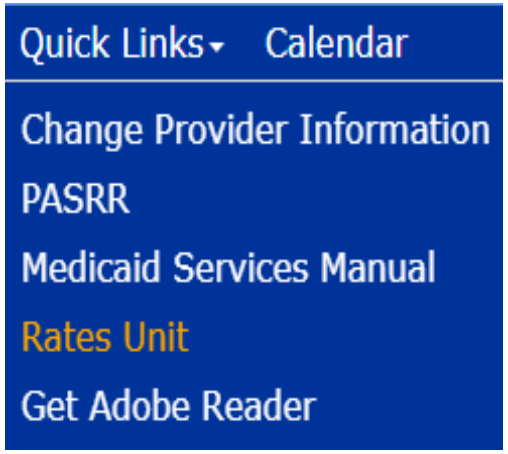
Search Results

Total Records: 6

Procedure	Provider Type	Provider Specialty	Modifier	Fee Amount	Age Restrictions	Effective Date
K0005-Ultralightweight wheelchair	033-Durable Medical Equipment (DME), Disposable, Prosthetics	000-No Specialty	NU-New equipment	$1,805.12	REGULAR	8/1/2011 - 12/31/9999
K0005-Ultralightweight wheelchair	033-Durable Medical Equipment (DME), Disposable, Prosthetics	000-No Specialty	RR-Rental (DME)	$180.51	REGULAR	8/1/2011 - 12/31/9999
K0005-Ultralightweight wheelchair	033-Durable Medical Equipment (DME), Disposable, Prosthetics	000-No Specialty	UE-Used durable med equipmen	$1,353.85	REGULAR	8/1/2011 - 12/31/9999
K0005-Ultralightweight wheelchair	033-Durable Medical Equipment (DME), Disposable, Prosthetics	000-No Specialty	NU-New equipment	$1,817.84	REGULAR	1/1/1980 - 7/31/2011
K0005-Ultralightweight wheelchair	033-Durable Medical Equipment (DME), Disposable, Prosthetics	000-No Specialty	RR-Rental (DME)	$181.78	REGULAR	1/1/1980 - 7/31/2011
K0005-Ultralightweight wheelchair	033-Durable Medical Equipment (DME), Disposable, Prosthetics	000-No Specialty	UE-Used durable med equipmen	$1,363.39	REGULAR	1/1/1980 - 7/31/2011

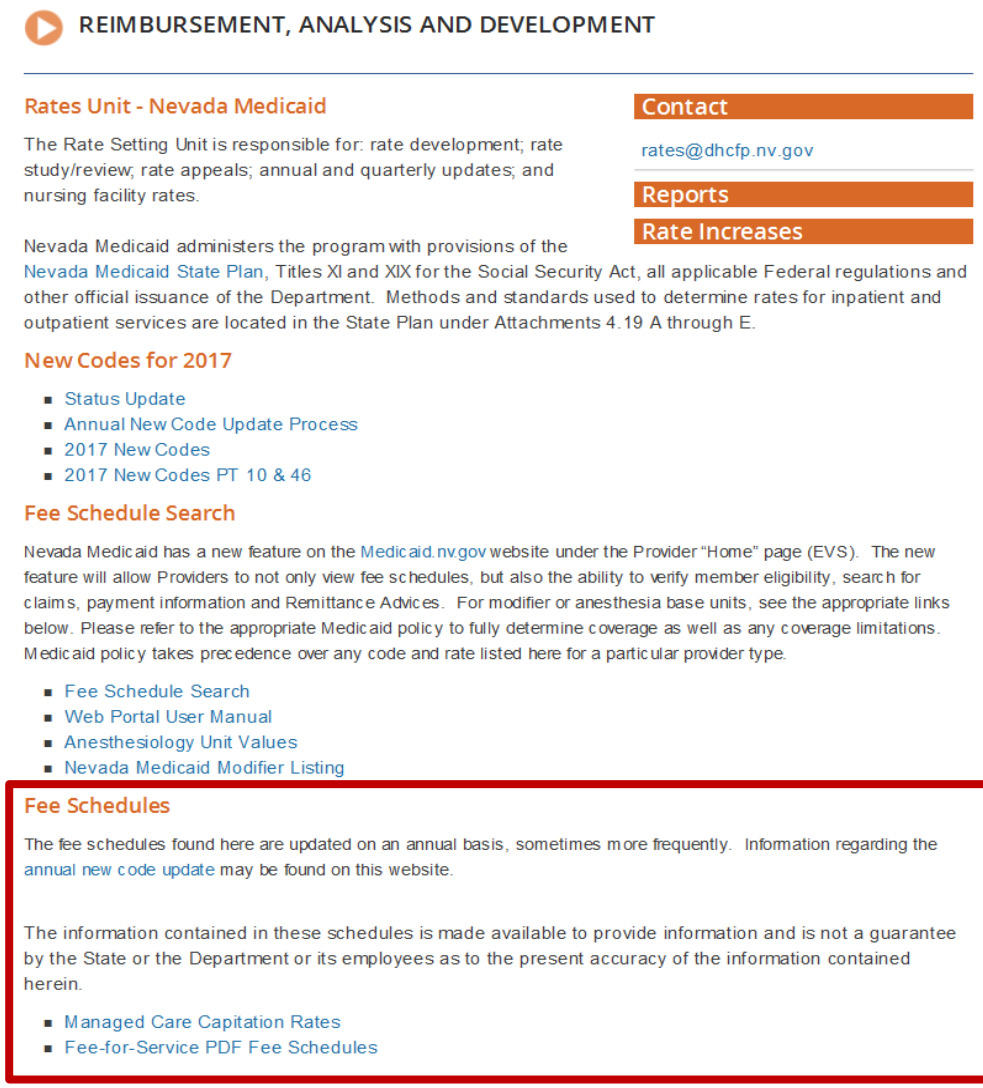
– Note: Make sure that the “Effective Date” ends in 9999 for current rates of reimbursement

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"

Rates Unit, continued



REIMBURSEMENT, ANALYSIS AND DEVELOPMENT

Rates Unit - Nevada Medicaid

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

Contact

rates@dhcfp.nv.gov

Reports

Rate Increases

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

New Codes for 2017

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

Fee Schedule Search

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

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

Fee Schedules

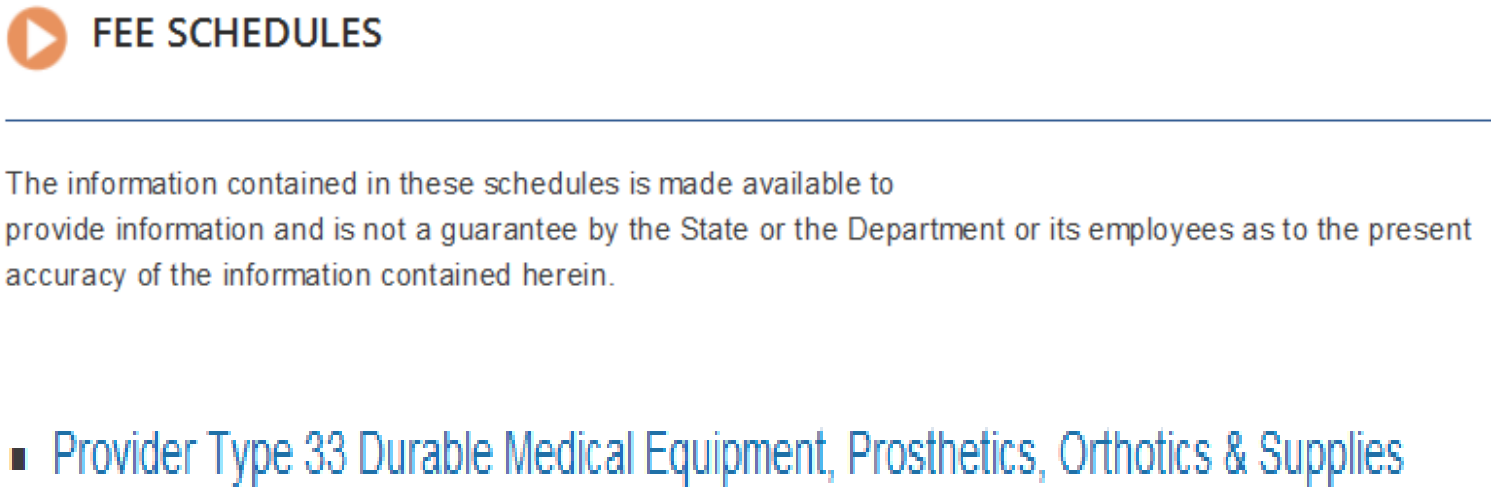
The fee schedules found here are updated on an annual basis, sometimes more frequently. Information regarding the annual new code update may be found on this website.

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

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

– Locate the "Fee-for-Service PDF Fee Schedules" from the Fee Schedules section

Rates Unit, continued



– Select the appropriate title to open the PDF pertaining to the reimbursement schedule you would like to review

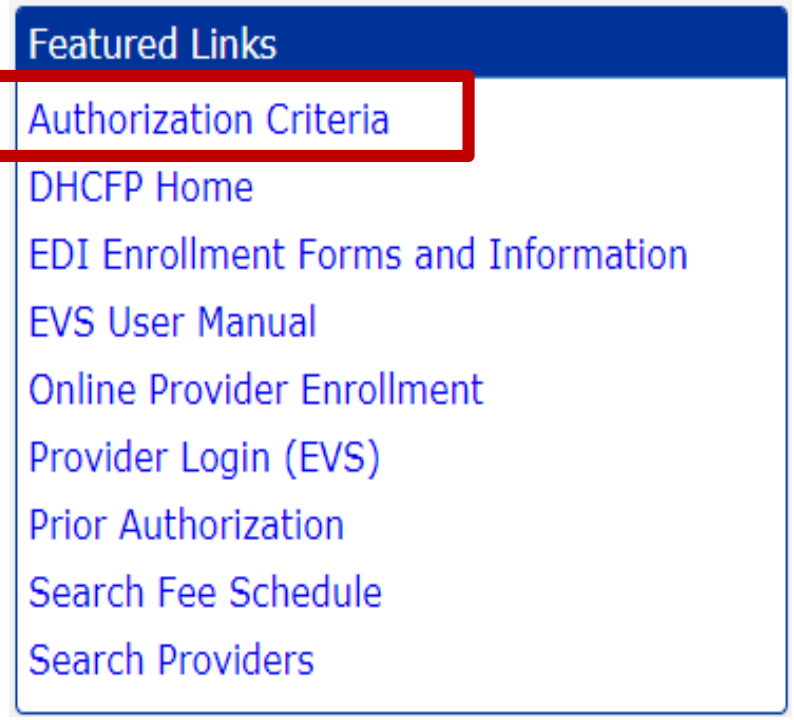
Authorization Criteria Function

Authorization Criteria

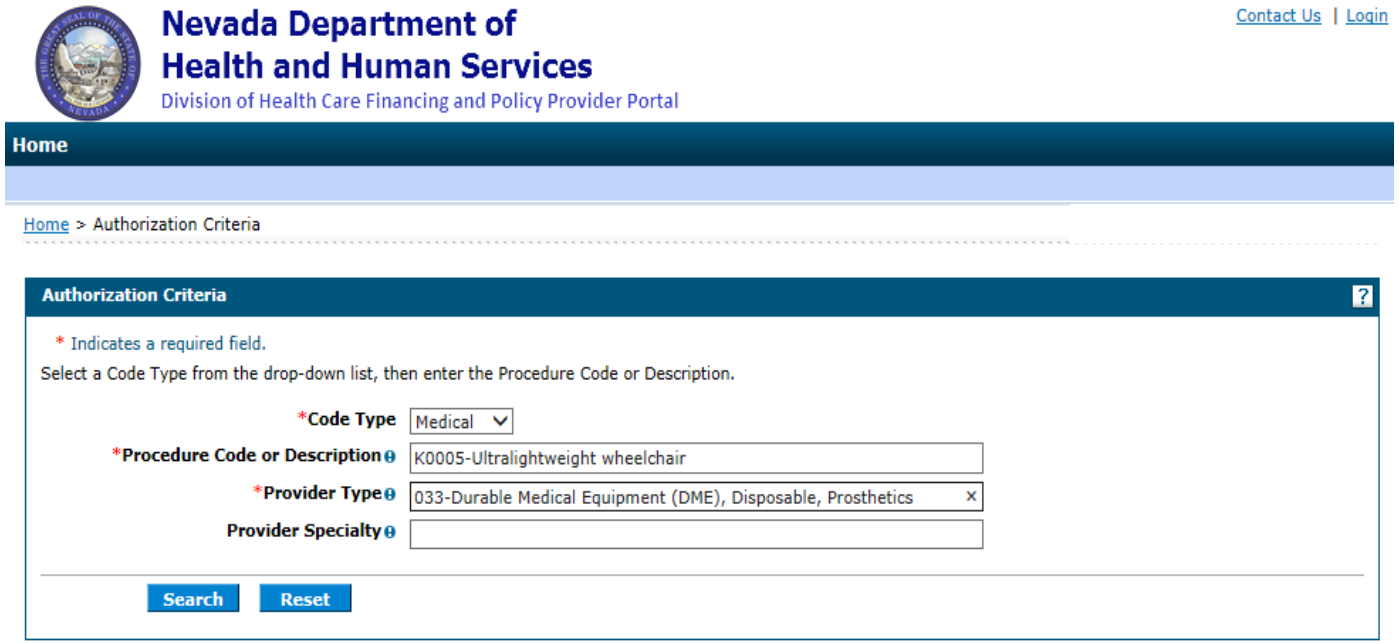
- The Authorization Criteria tool on the Provider Web Portal allows a user to input a procedure code to determine if a Prior Authorization (PA) is required
- If the search criteria does not return any results, providers are encouraged to verify all PA requirements by referring to the Medicaid Services Manual (MSM) Chapter for your service type at dhcfp.nv.gov and the Billing Guide for your provider type at www.medicaid.nv.gov

Authorization Criteria

– Authorization Criteria is located at www.medicaid.nv.gov under “Featured Links”

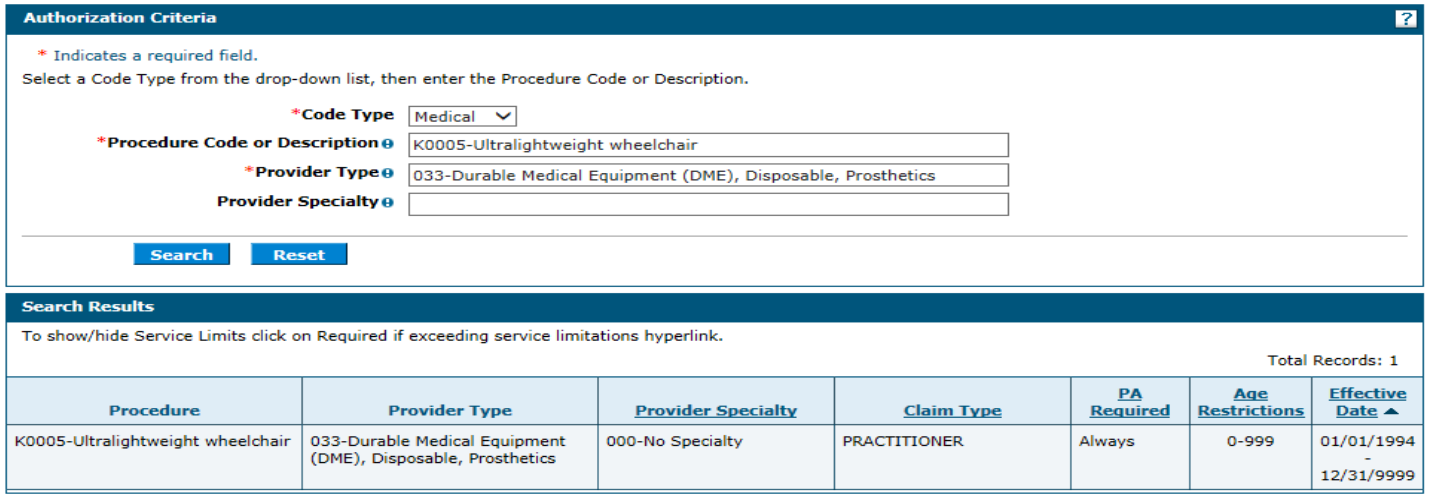


Authorization Criteria, continued



- Step 1 – Select “Code Type”
- Step 2 – Input either a Procedure Code or Description. This field uses a predictive search.
- Step 3: Input Provider Type. Note that “0” must be input before the typical two-digit provider type.
- Step 4: Select “Search”
- Step 5: Results will then populate on the next screen

Authorization Criteria, continued



Authorization Criteria

* Indicates a required field.

Select a Code Type from the drop-down list, then enter the Procedure Code or Description.

*Code Type: Medical

*Procedure Code or Description: K0005-Ultralightweight wheelchair

*Provider Type: 033-Durable Medical Equipment (DME), Disposable, Prosthetics

Provider Specialty:

Search | Reset

Search Results

To show/hide Service Limits click on Required if exceeding service limitations hyperlink.

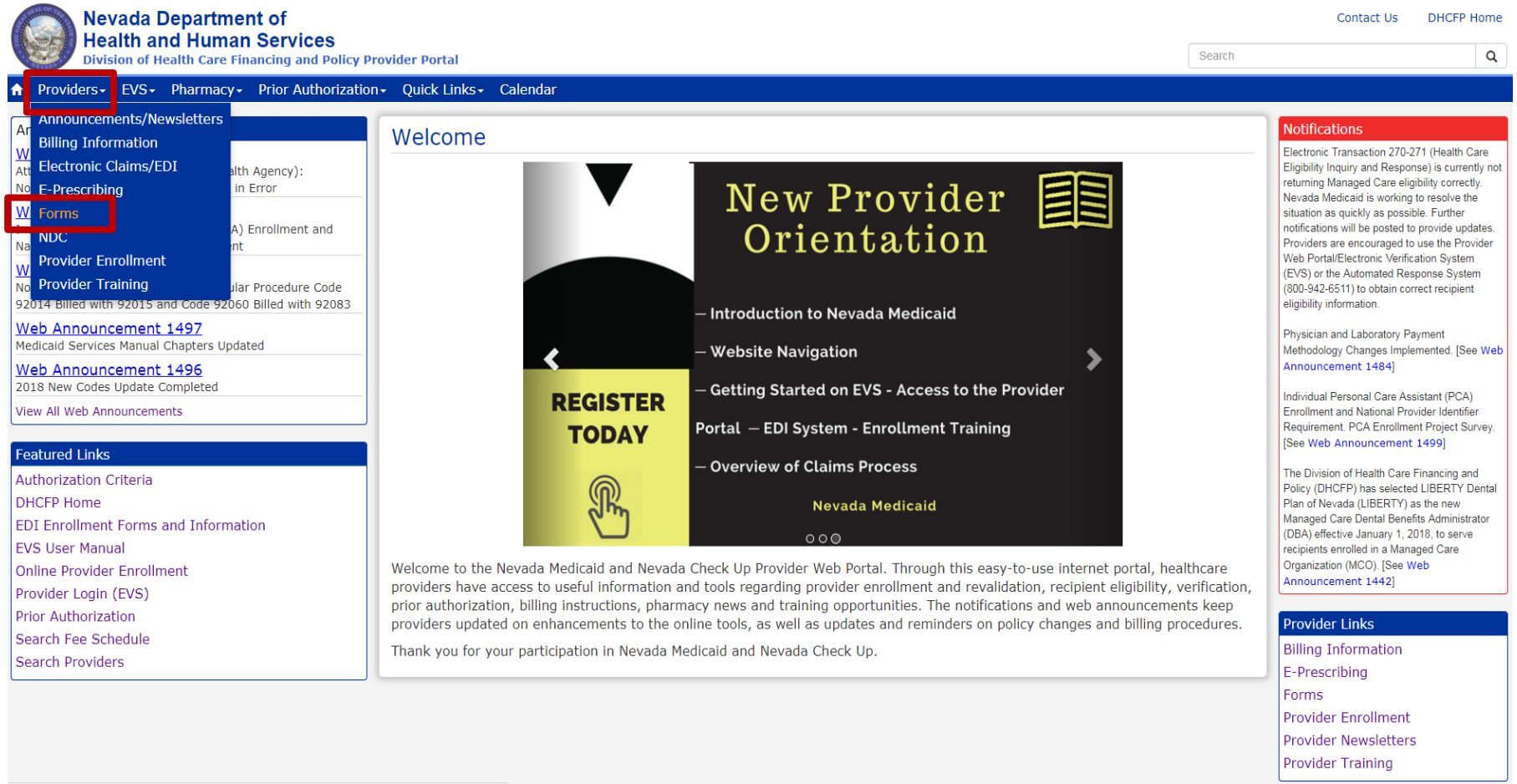
Total Records: 1

Procedure	Provider Type	Provider Specialty	Claim Type	PA Required	Age Restrictions	Effective Date
K0005-Ultralightweight wheelchair	033-Durable Medical Equipment (DME), Disposable, Prosthetics	000-No Specialty	PRACTITIONER	Always	0-999	01/01/1994 - 12/31/9999

- Make sure that the effective date ends in “9999” to verify that the user is viewing the most accurate information

Prior Authorization Forms

Locating DME Prior Authorization Forms



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

Prior Authorization Forms, continued

FA-1	Durable Medical Equipment Prior Authorization Request
FA-1A	Usage Evaluation for Continuing Use of BIPAP and CPAP Devices
FA-1B	Mobility Assessment and Prior Authorization (PA), Revised 12/29/10
FA-1B Instructions	Mobility Assessment and Prior Authorization (PA) Instructions
FA-1C	Oxygen Equipment and Supplies Prior Authorization Request
FA-1D	Wheelchair Repair Form

- While on the “Forms” page, locate the appropriate FA-1 Form and its instructions, if applicable
- All active forms are fillable for easy uploading for PA submission online
- Any form that is not legible will not be accepted

Prior Authorization Forms, continued

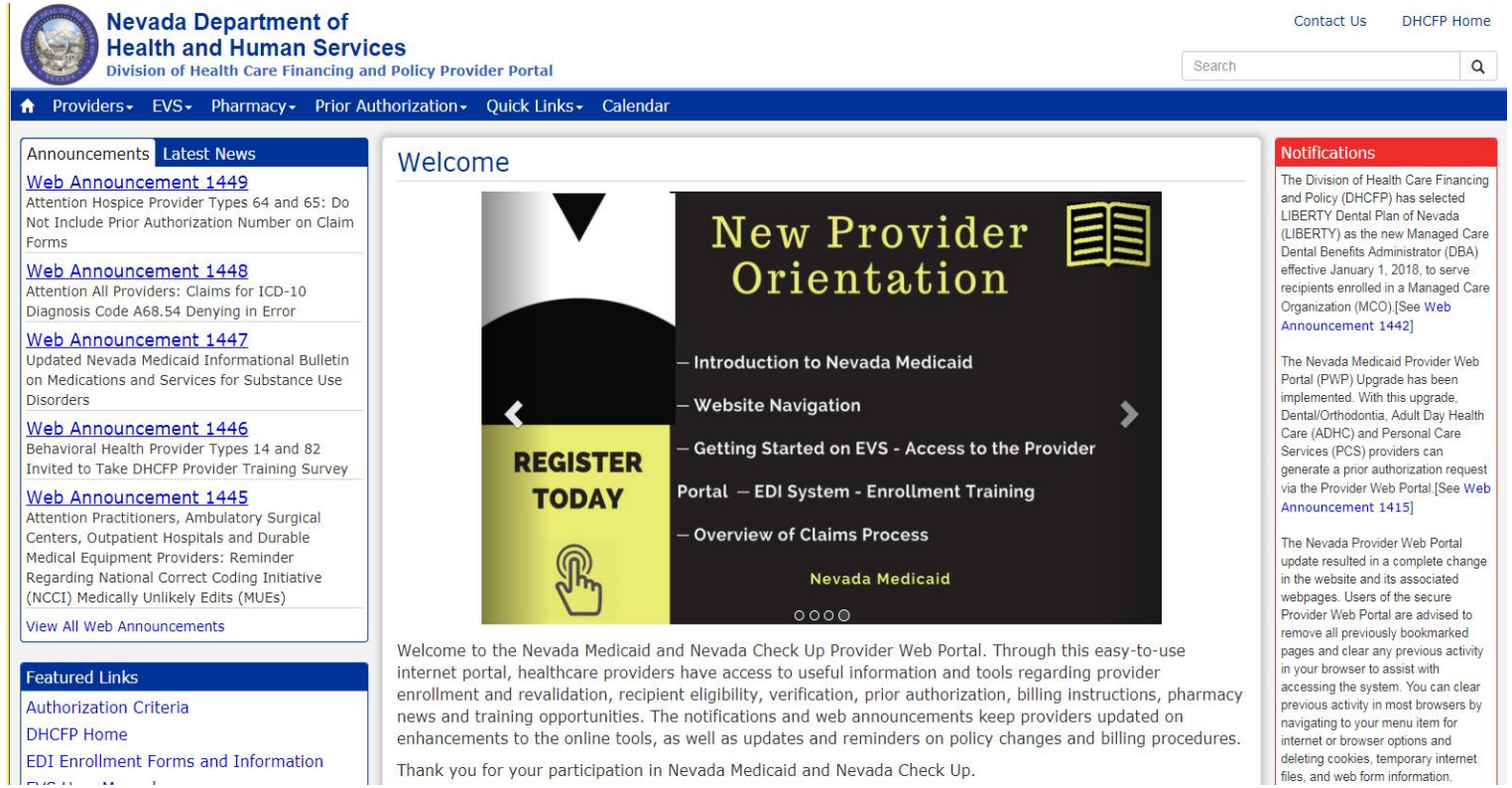
- FA-1 (Durable Medical Equipment Prior Authorization Request)
  - This form is not required when submitting the prior authorization request online
- FA-1A (Usage Evaluation for Continuing Use of BIPAP and CPAP Devices)
- FA-1B (Mobility Assessment and Prior Authorization (PA))
  - Use this form if the equipment is greater than $500.00
- FA-1C (Oxygen Equipment and Supplies Prior Authorization Request)
  - Use this form when requesting Oxygen Equipment (Example: E1390, E1392, E0431, E0433 & K0738)
- FA-1D (Wheelchair Repair Form)

Prior Authorization Forms: Tips

- All PA forms must be submitted at least 3 business days prior to the start date unless recipient is being discharged from a hospital.
- Retro dates are only accepted if recipient has retro eligibility coverage and holidays and weekends are not considered business days.
- Use the Search Fee Schedule to determine appropriate modifier. Note that some procedure codes can be overridden per Nevada Medicaid Policy. Some modifiers, i.e., rental, will be paid up to the purchase amount.
- Divide the NU modifier purchase amount by the RR Modifier rental amount to find the months of rental needed to meet the purchase price.
- Repairs to equipment must have an RB Modifier along with the appropriate code to prevent claim denials. See Web Announcement 661 at www.medicaid.nv.gov.
- Rental codes cannot use the NU modifier.
- Some codes are 1 unit per day.

EVS Secure Web Portal

Provider Web Portal
www.medicaid.nv.gov



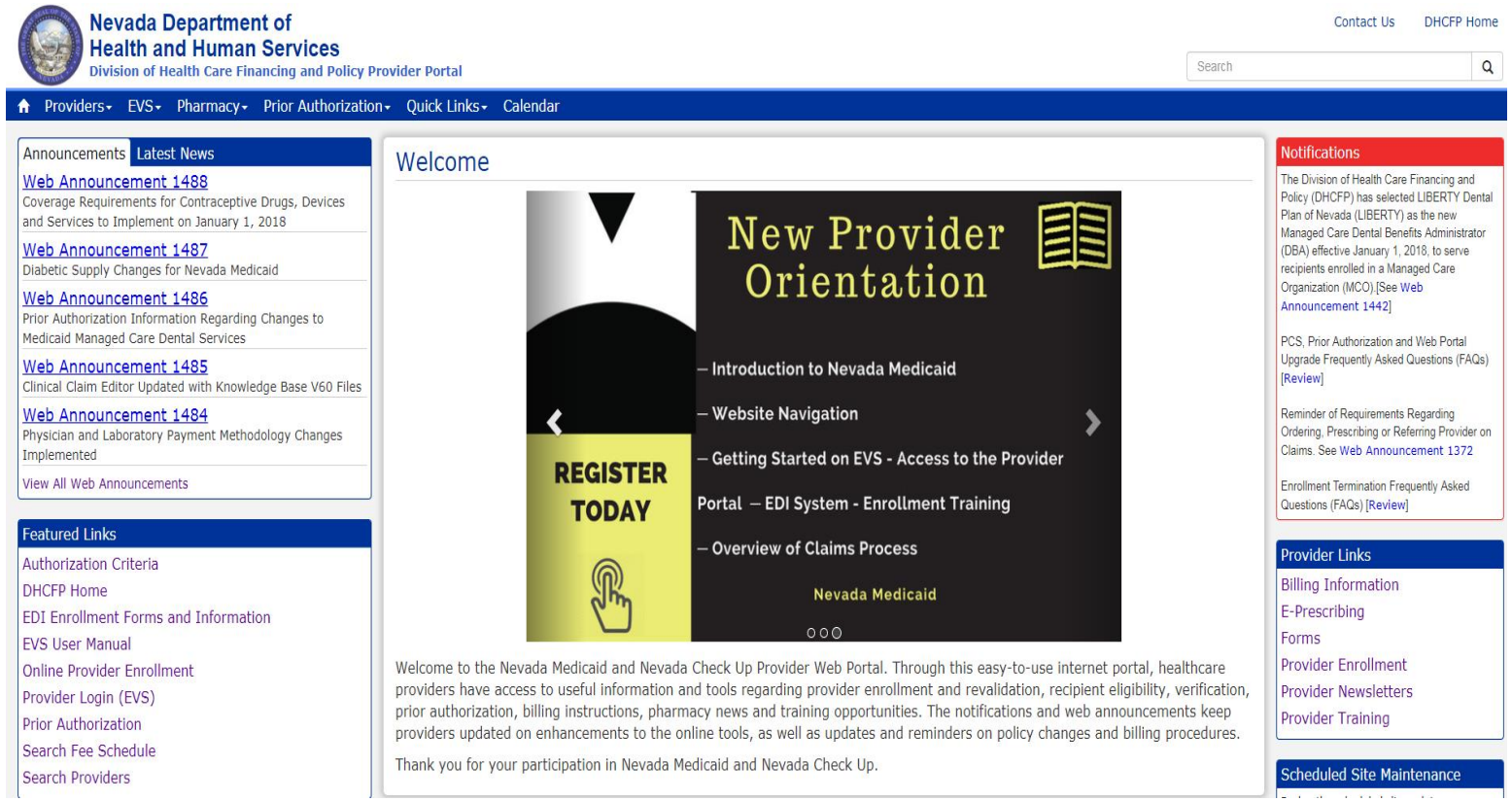
EVS

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

System Requirements

To access EVS, you must have internet access and a computer with a web browser (Microsoft Internet Explorer 9.0 or higher, Mozilla Firefox, or Google Chrome recommended)

EVS Secure Web Portal

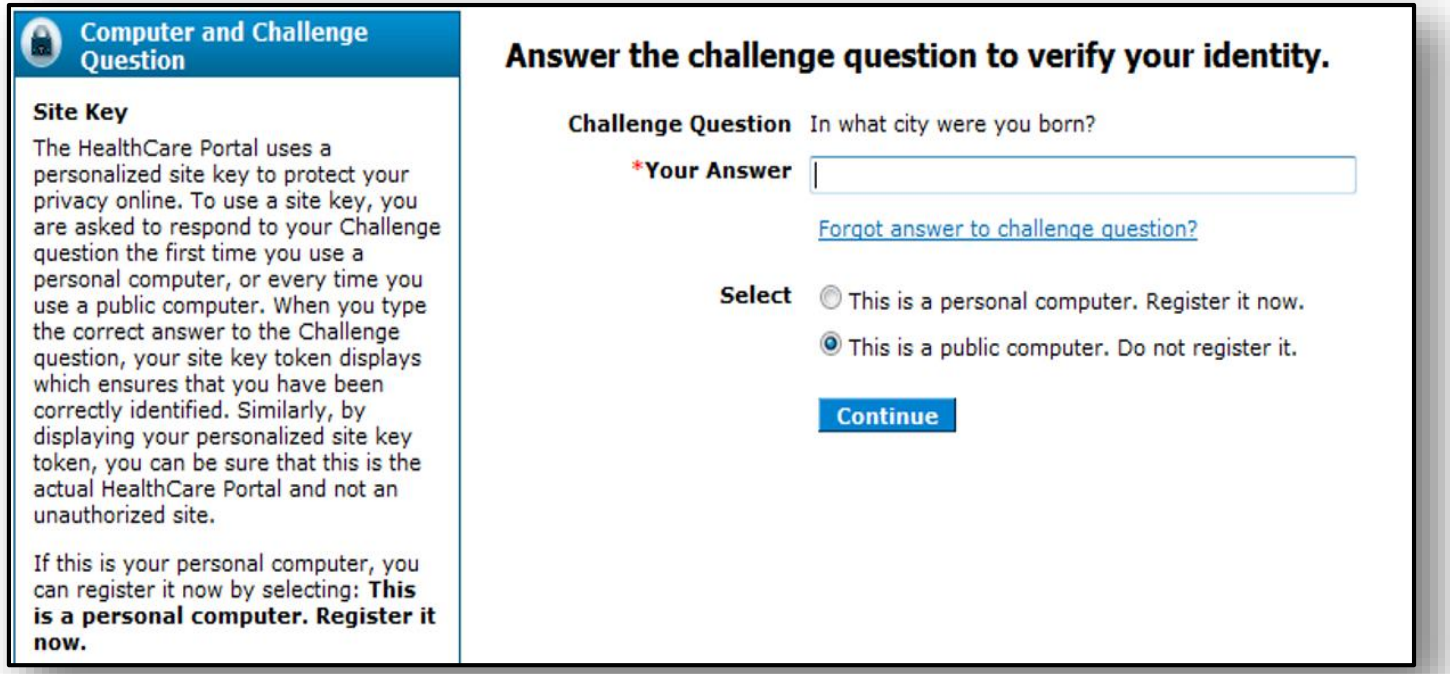


– EVS can be accessed by highlighting EVS from the top tool and select “Provider Login” or “Provider Login” can be selected from the Featured Links section

EVS Secure Web Portal, continued

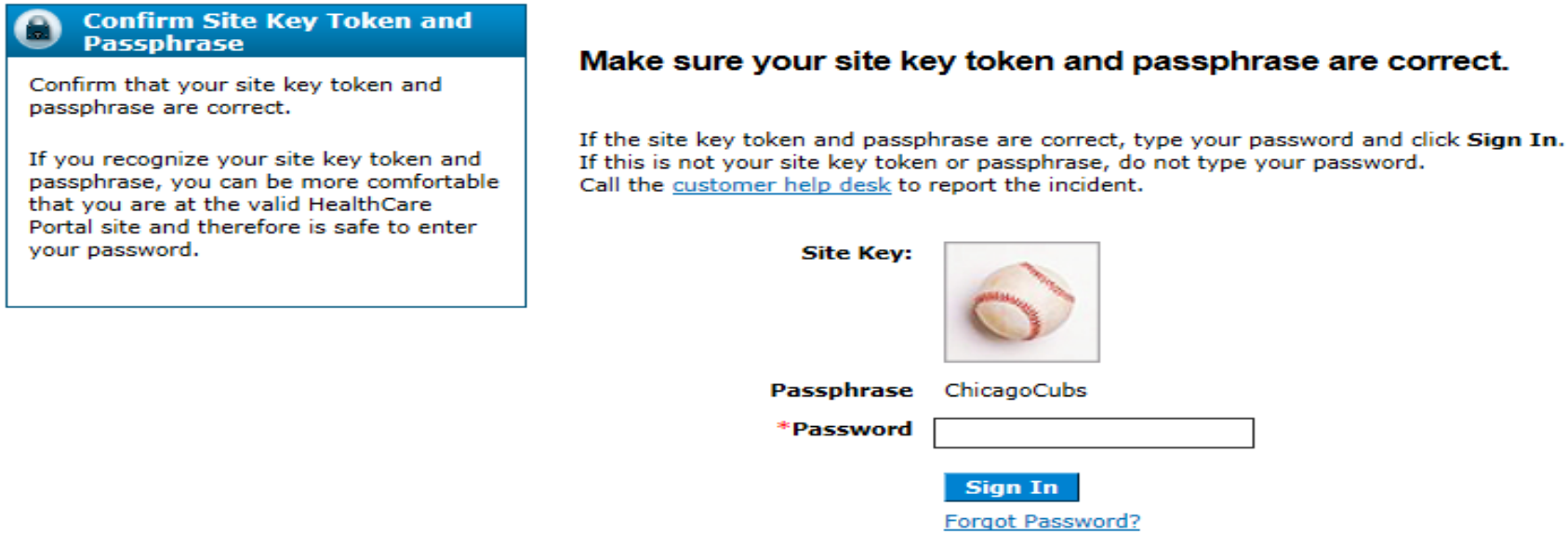
- Step 1: Input User ID
- Step 2: Select “Log In”
- If an account has not been created, select “Register Now” to begin creating a web portal account. See Chapter 1: Getting Started of the EVS User Manual for reference.

EVS Secure Web Portal, continued



- Answer the challenge question to verify your identity the first time you log in from a personal computer or every time you use a public computer
- Select personal computer or a public computer
- Click “Continue”

EVS Secure Web Portal, continued

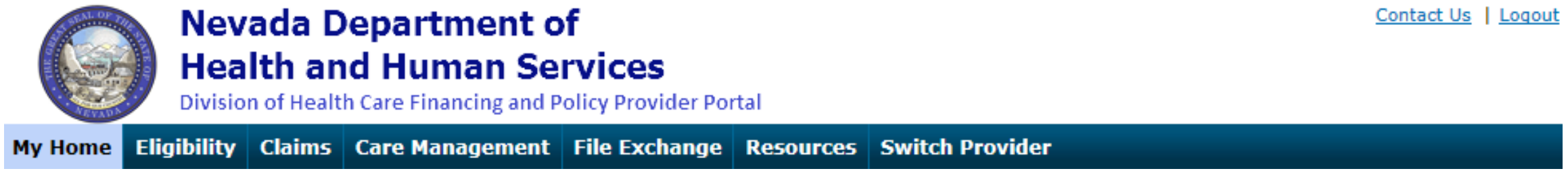


- Confirm that your **site key token** and **passphrase** are correct. If you recognize your site key token and passphrase, you can be assured that you are at the valid Provider Web Portal website and it is safe to enter your password.
- Enter your Password
- Select “Forgot Password” to start the reset process

EVS Secure Web Portal, continued

- Verify all Provider Information
- Utilize Provider Services
- Use “Contact Us” or “Secure Correspondence” to contact Nevada Medicaid

EVS Secure Web Portal, continued



My Home

Confirm provider information and contact information and check messages.

Eligibility

Search recipient eligibility information.

Claims

Search claims and payment history.

Care Management

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

File Exchange

Upload forms online.

Resources

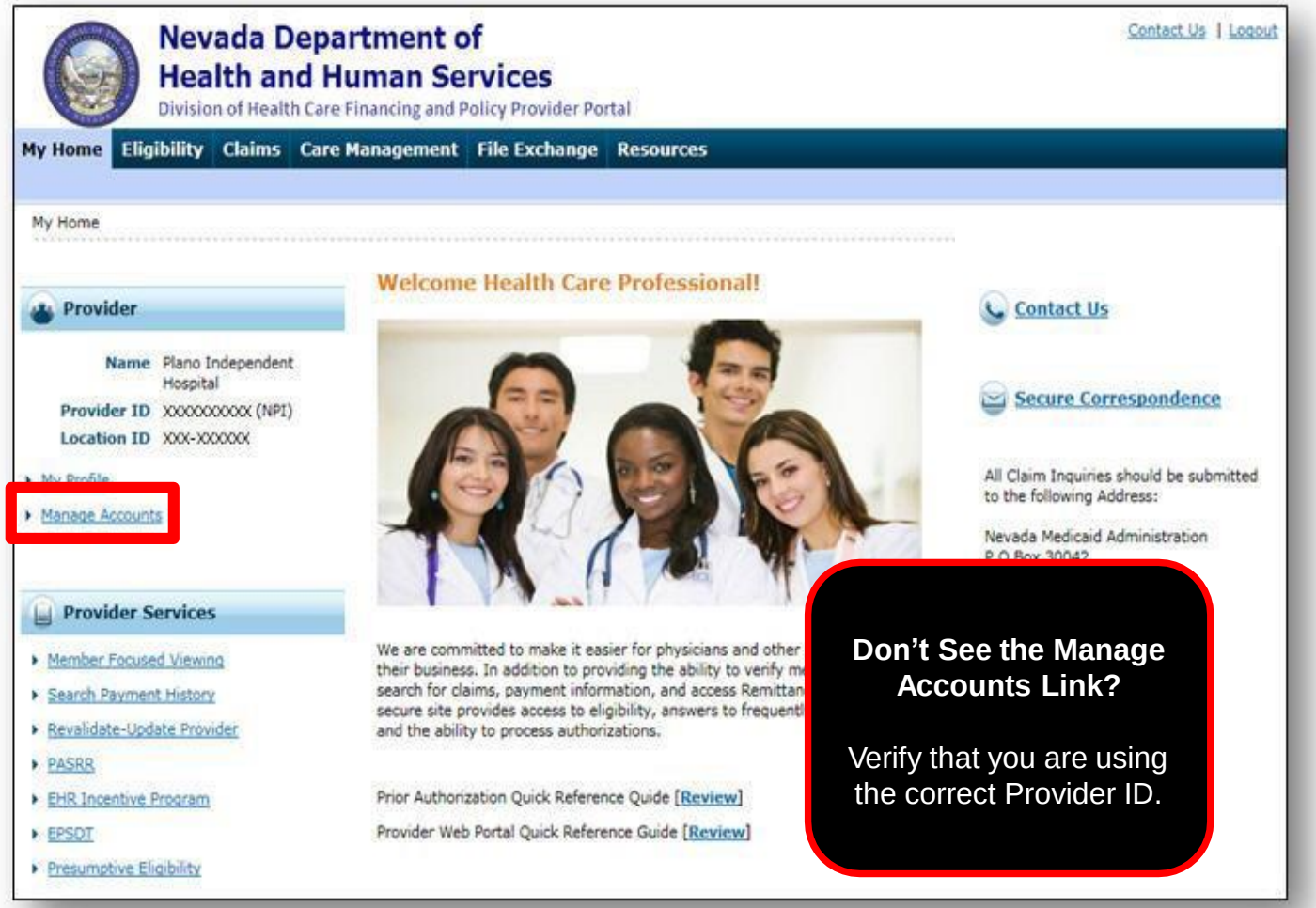
Download forms and documents.

Role-Based Security and Delegate Access

Granting Access to a Delegate

- A new delegate is a person who does not currently have a delegate code, including a code that was created by someone else
- An existing delegate is a person who was previously provided with a delegate code and is registered for a portal account
- Each delegate should only have one delegate code, which is created by the first provider to add them as a delegate

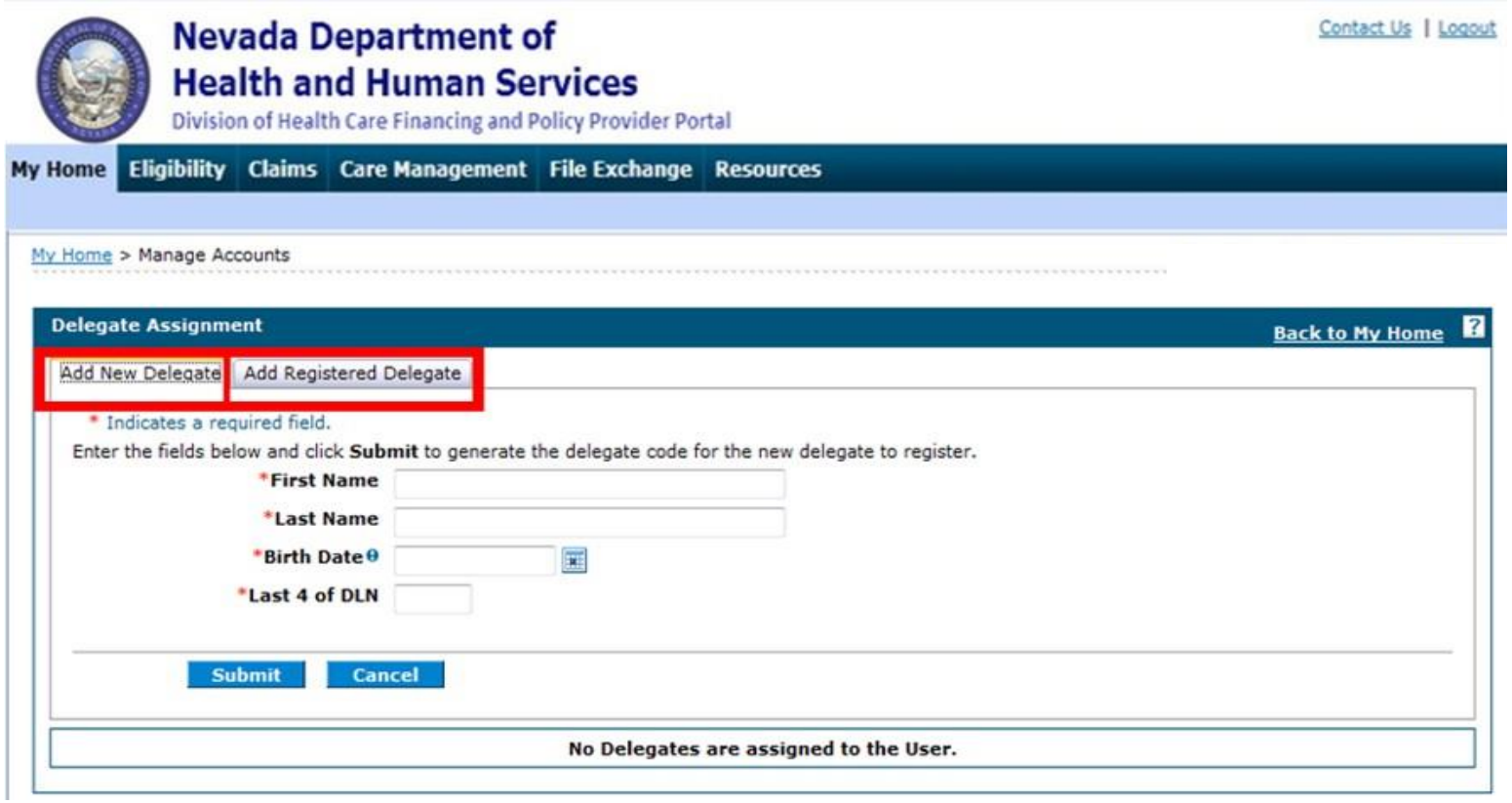
1. Log in to “Provider Web Portal”
2. Click “Manage Accounts”



Delegate Assignment Tabs

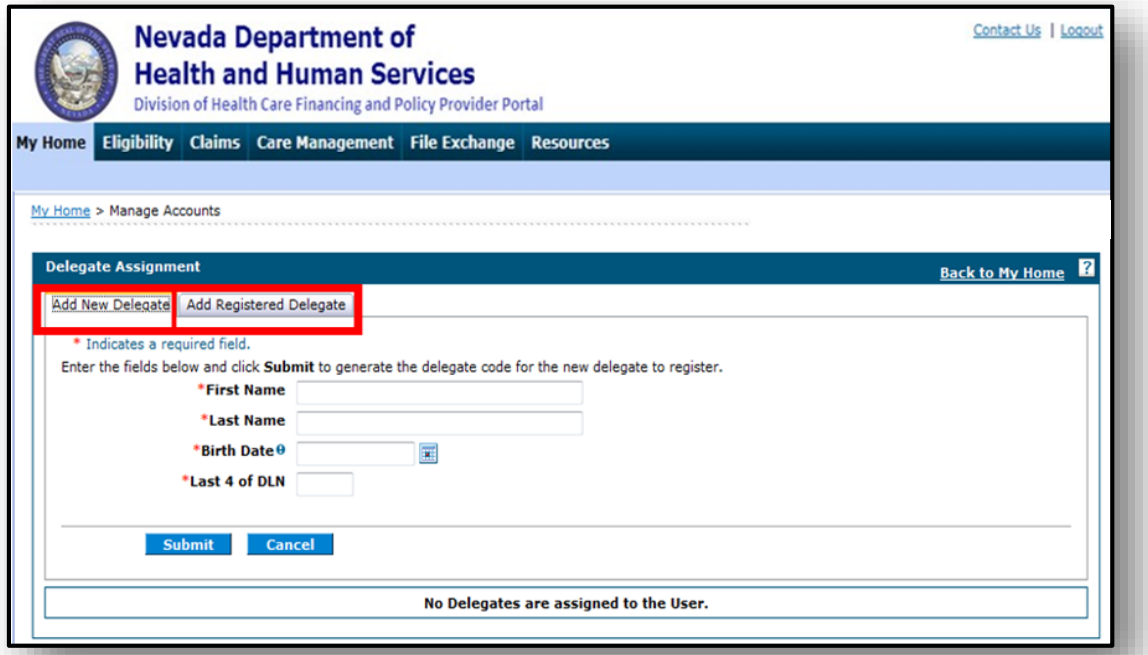
- Add New Delegate
- Add Registered Delegate

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



Delegate Assignment

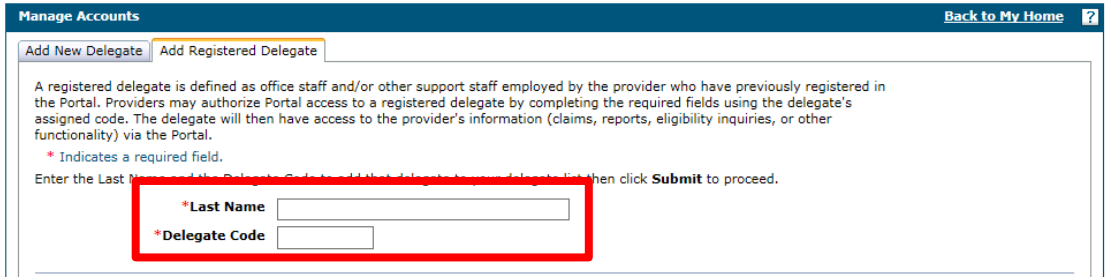
Add New Delegate



Enter the delegate's:

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

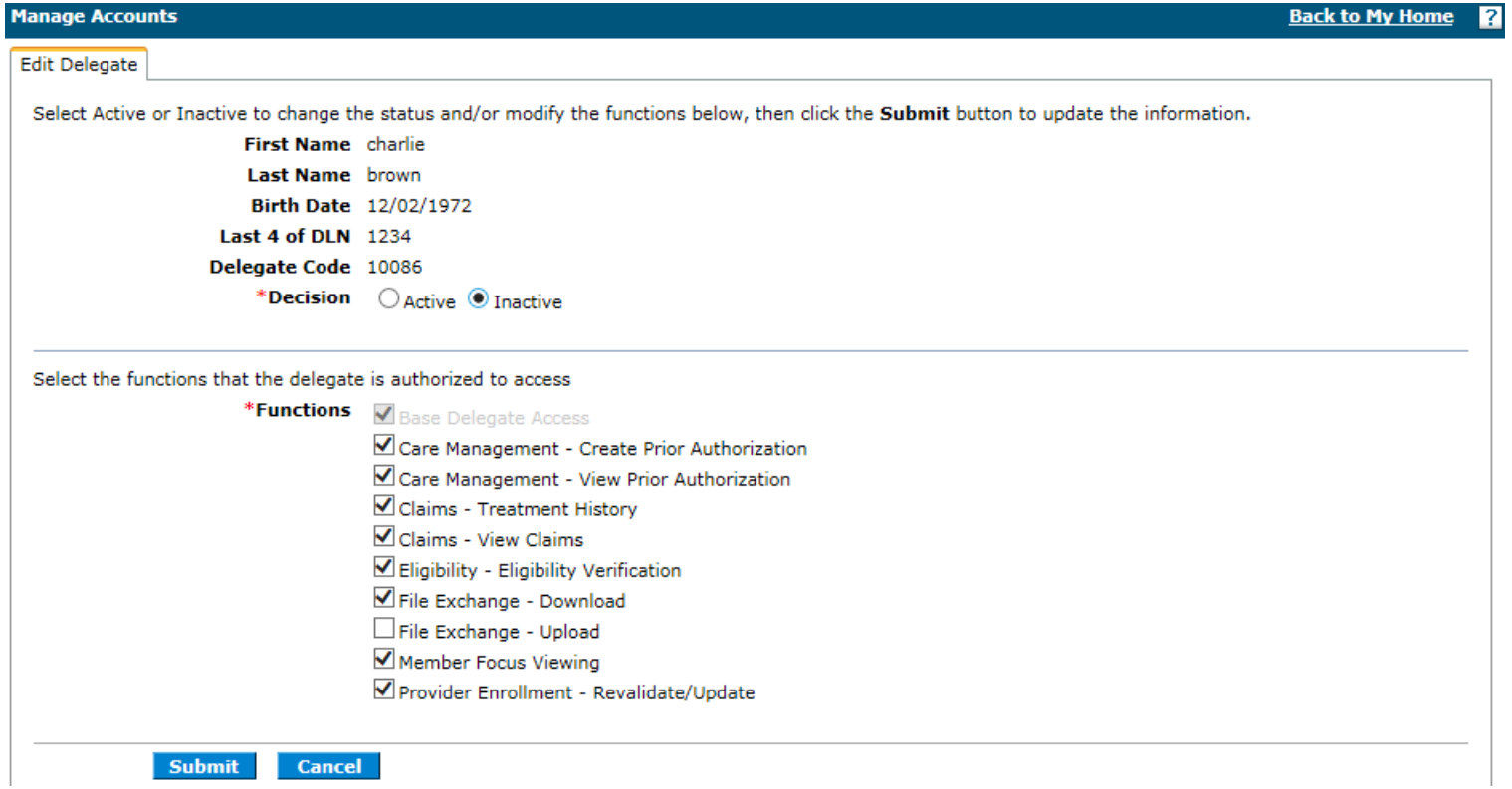
Add Registered Delegate



Enter the delegate's:

- Last Name and previously provided Delegate Code

Delegate Assignment, continued



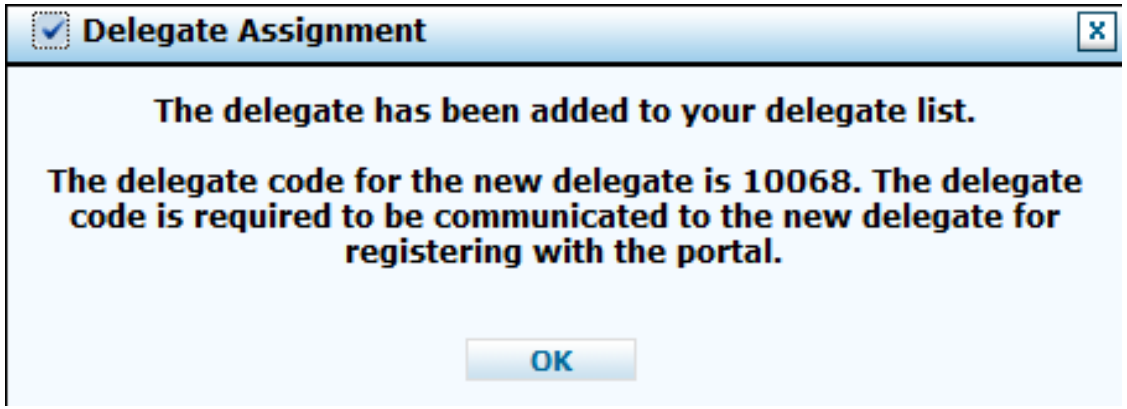
- Choose the Functions you want the delegate to be able to perform
- Click "Confirm"

Edit Delegate

- Make the appropriate changes to the functionality for the delegate
- To remove the delegate's ability to have access to your Portal, chose **Inactive**
- When changes are complete, click "Submit"

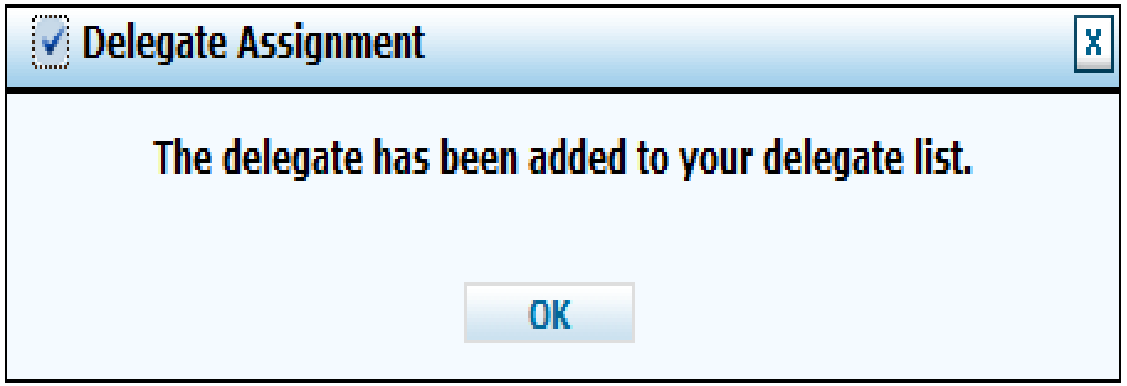
Delegate Assignment, continued

New Delegate



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

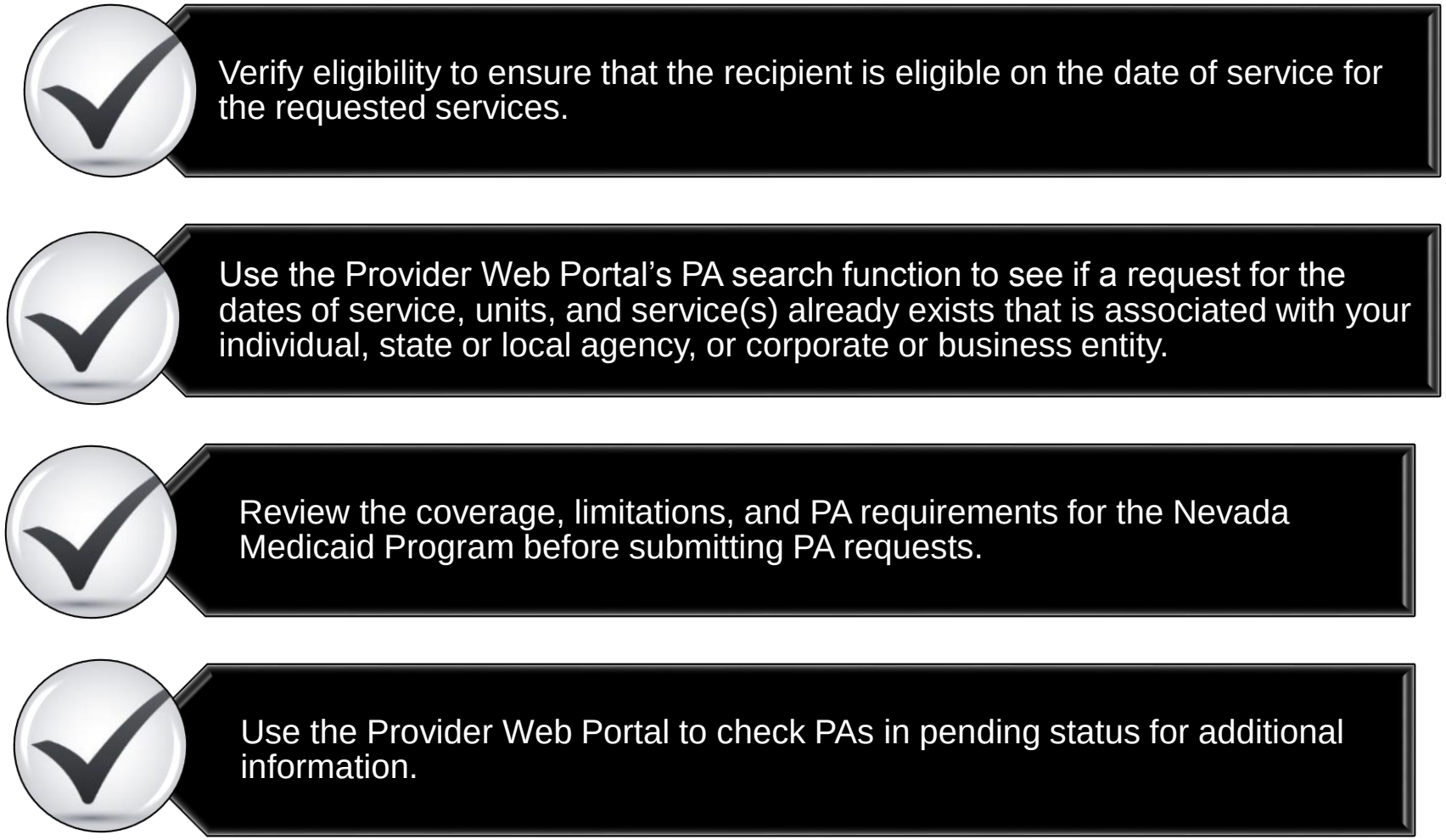
Registered Delegate



- A Delegate Assignment box will be displayed to confirm that the delegate was added to the provider's delegate list.

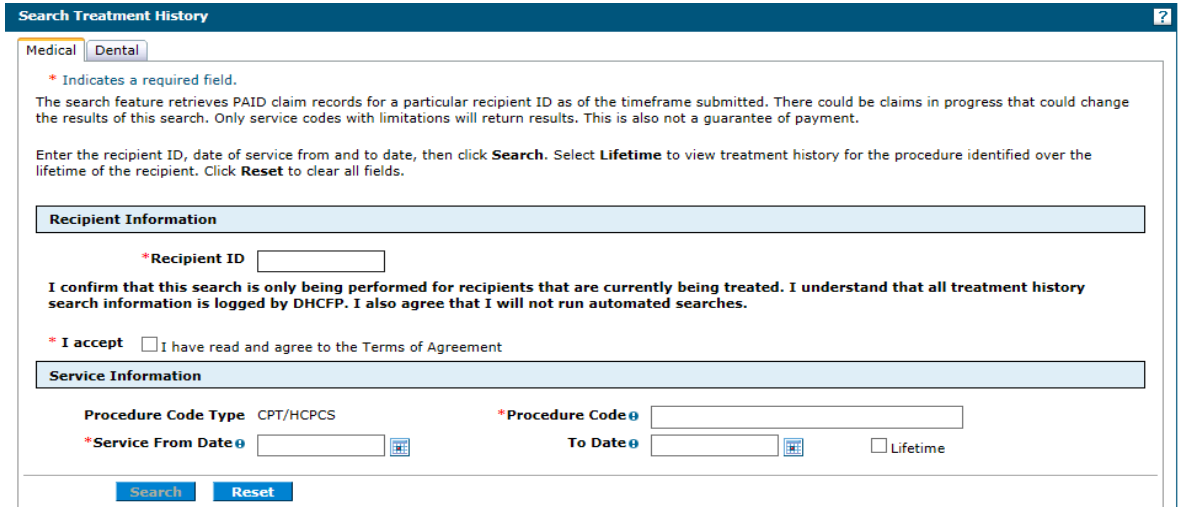
Before You Create a Prior Authorization

Before Creating a Prior Authorization



Treatment History

Treatment History



- Utilize the “Treatment History” sub-menu from the Claims menu
- Treatment History allows a user to indicate a Recipient ID and additional information to determine the recipient’s previous treatments
- All fields marked with a red asterisk are required
- Select “Search” to populate results

Create a Prior Authorization Request

Key Information

Recipient Demographics

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

Diagnosis Codes

- All PAs will require at least one valid diagnosis code

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

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

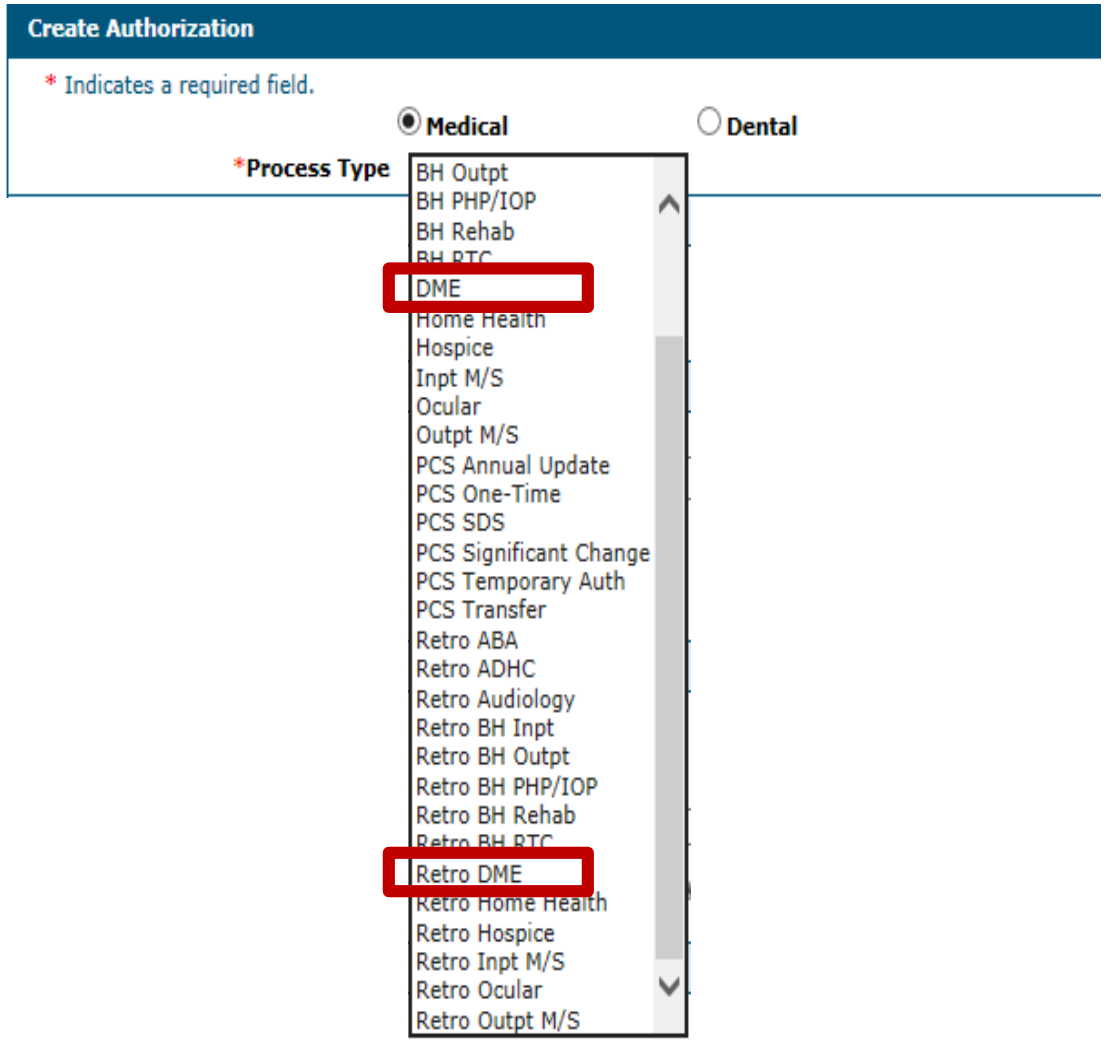
PA Attachments

- Attachments are required with all PA requests
- Attachments can be submitted electronically, by mail or by fax
- PA requests received without an attachment will remain in pended status for 30 days
- If no attachment is received within 30 days, the PA request will automatically be cancelled

Create Authorization

- Hover over the Care Management tab or select Care Management from the top tool bar
- Click “Create Authorization” from the sub-menu

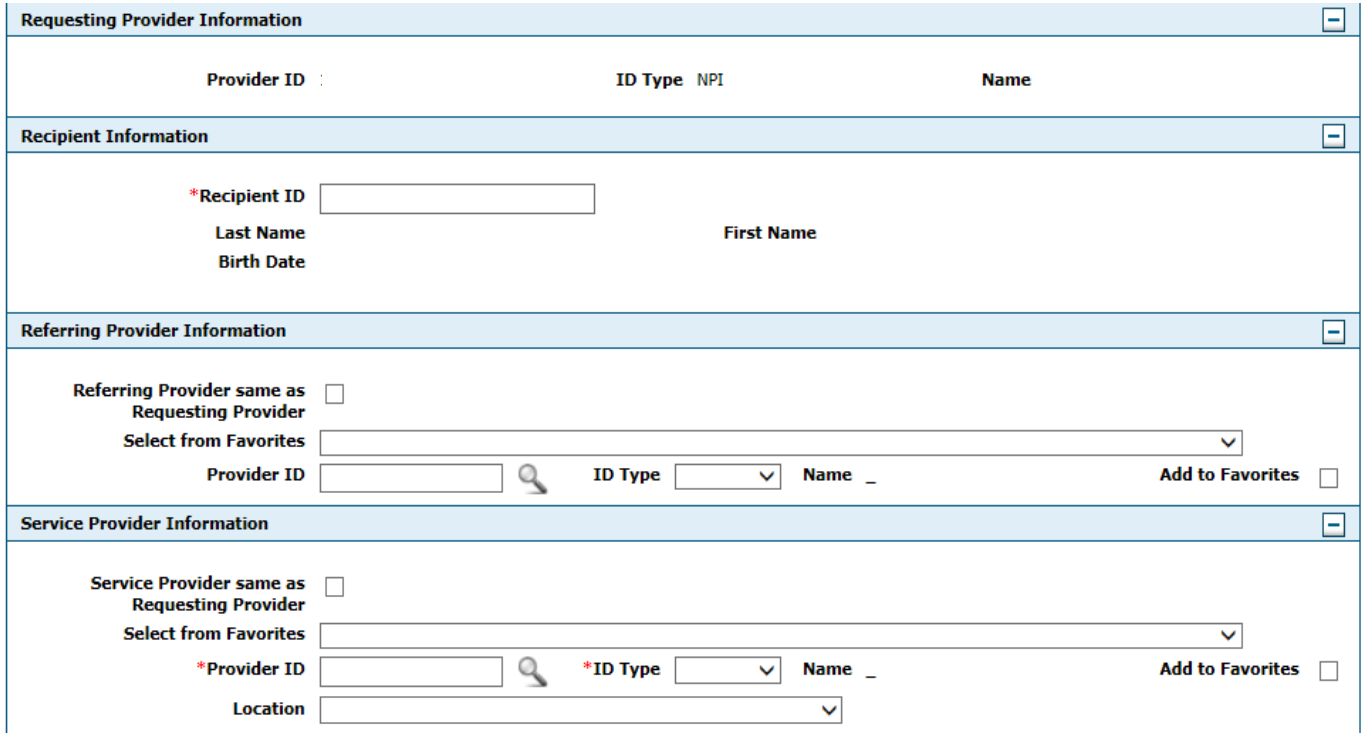
One Page Process for Prior Authorization Requests



- Step 1: Select the radio button next to “Medical”
- Step 2: Select appropriate DME Process Type

Create Medical Prior Authorization

Provider, Recipient, Referring and Servicing Provider Information



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

Requesting Provider Information

The information in this section is automatically populated

Recipient Information

Enter the Recipient ID

Referring Provider Information

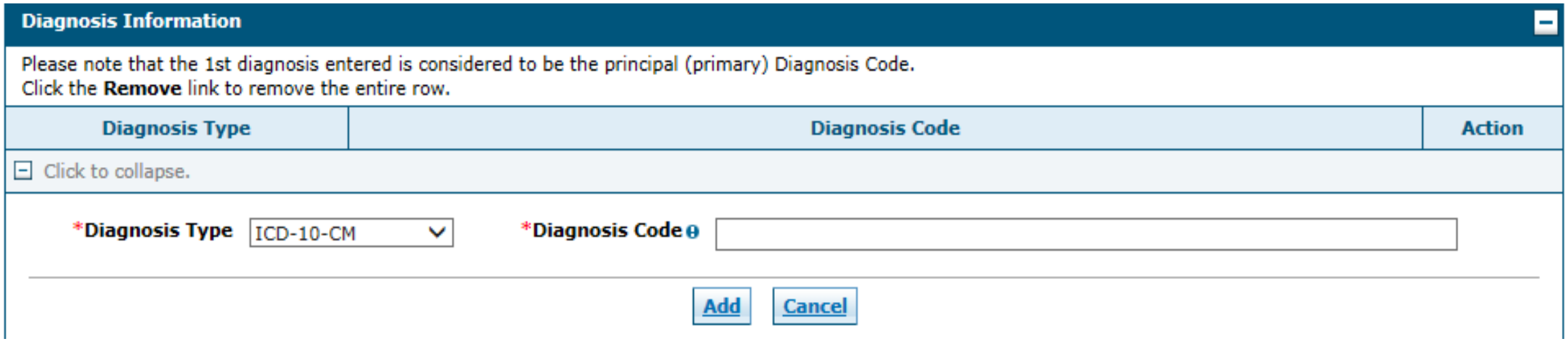
If there is a referring provider, complete one of the following options:

- Check the Referring Provider same as Requesting Provider box
- Use the Select from Favorites drop-down list to select a provider from your favorites list
- Enter the Provider ID and select the ID Type from the drop-down list

Service Provider Information

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

Diagnosis Information

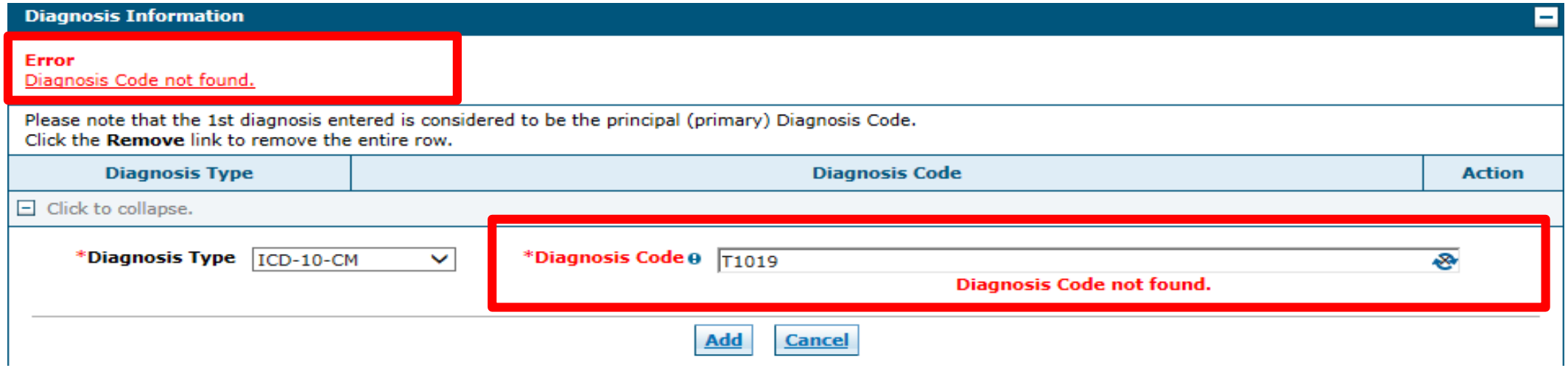


- The first diagnosis code entered is considered to be the principal or primary diagnosis code
- Portal allows up to nine diagnosis codes; one valid diagnosis code is required for the PA
- Click “Add” to add each diagnosis code

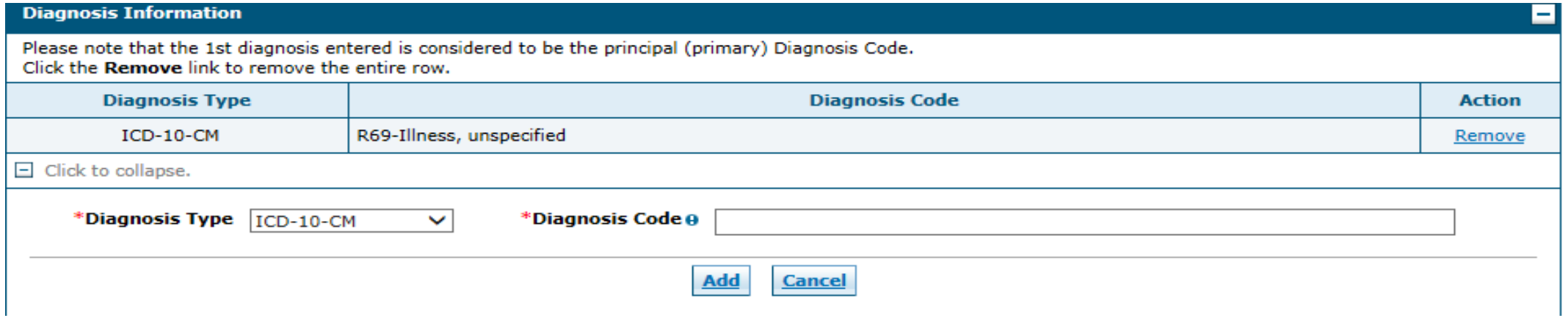
Do **not** key any decimals into the diagnosis code fields.

Diagnosis Information, continued

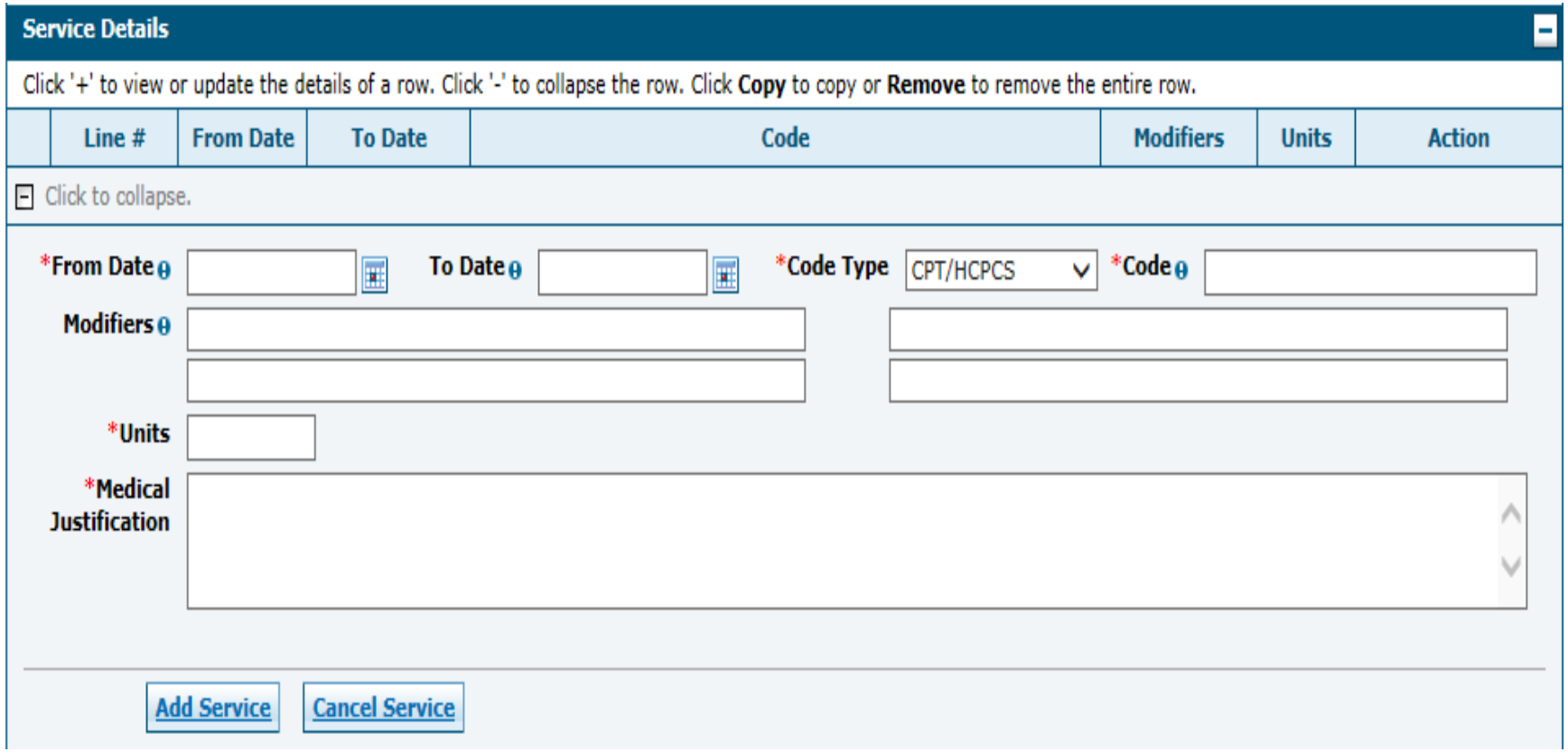
Invalid diagnosis code:



Valid diagnosis code:



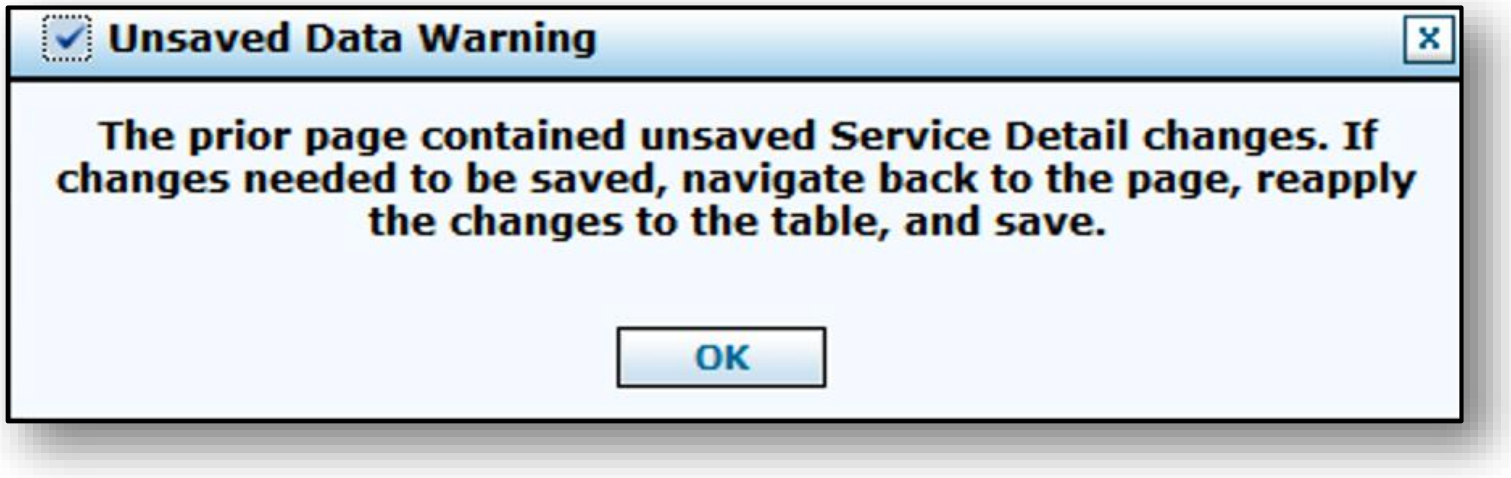
Service Details



- Indicate a “From” or start date
- Select a Code Type from the drop-down menu
- Input the Code
- Input amounts of Units being requested
- In the Medical Justification field, indicate “See attached form”
- Select “Add Service”

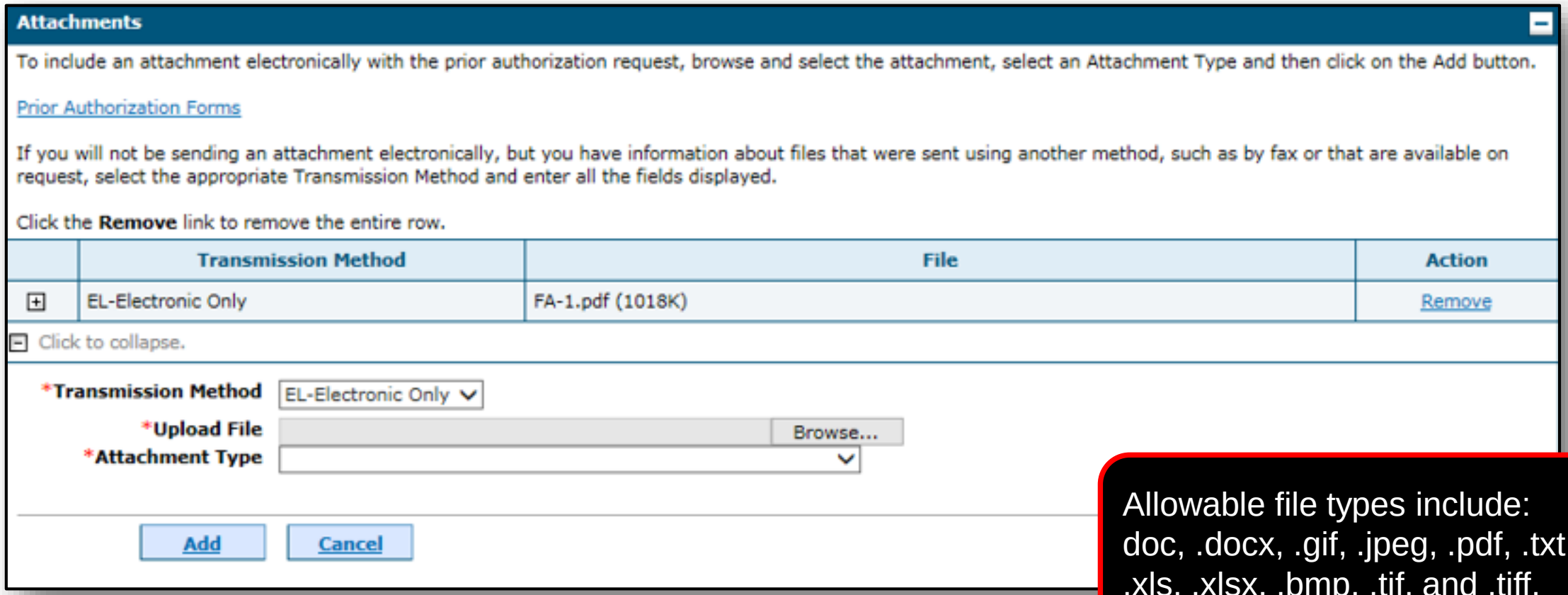
Unsaved Data Warning

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



Attachments

Attachment Requirements

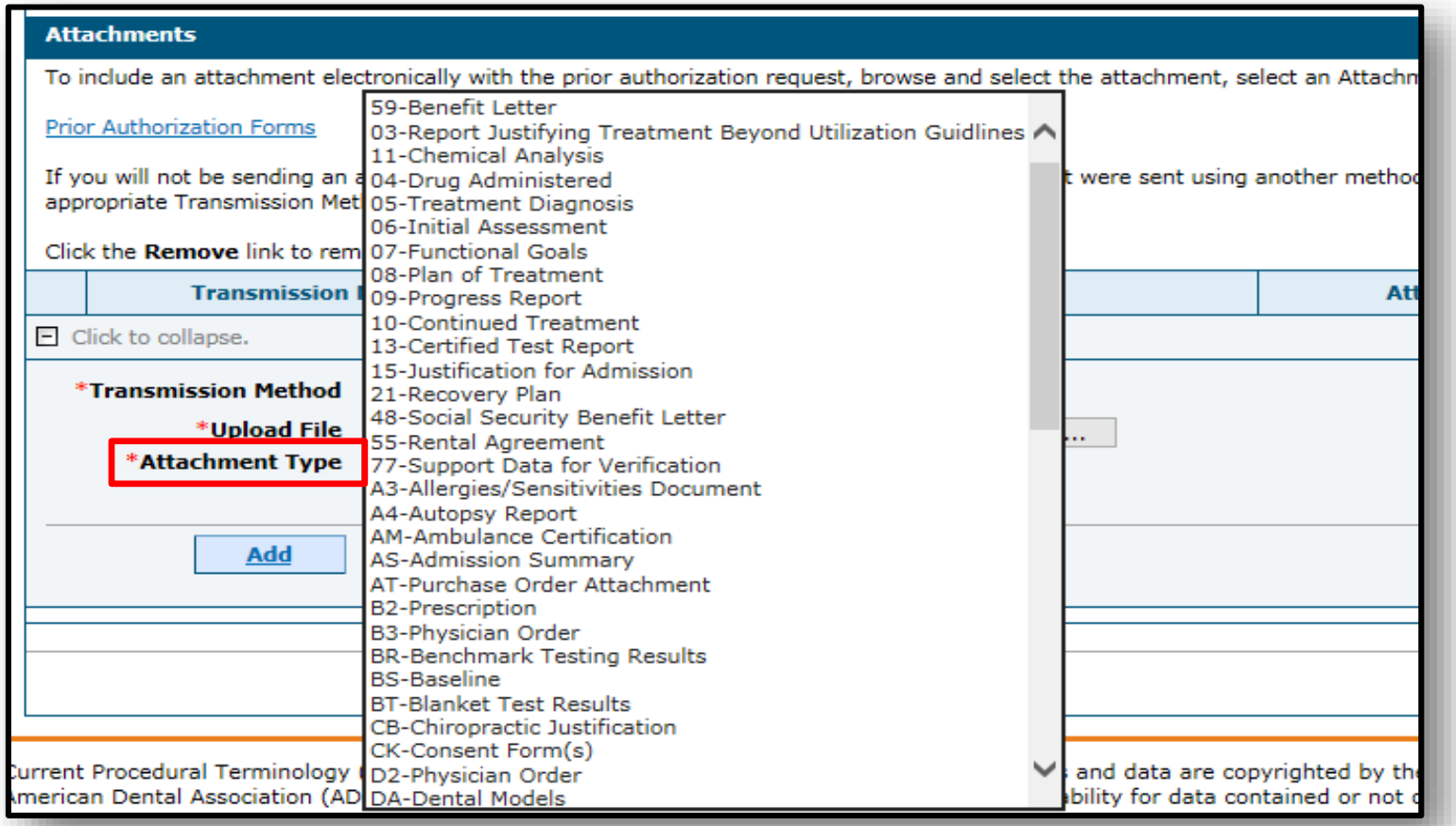


Allowable file types include: doc, .docx, .gif, .jpeg, .pdf, .txt, .xls, .xlsx, .bmp, .tif, and .tiff.

All PA requests require an attachment and any PA request that does not have an attachment submitted within 30 days will be automatically cancelled

Attachment Requirements, continued

– Choose the type of attachment being submitted from the drop-down list



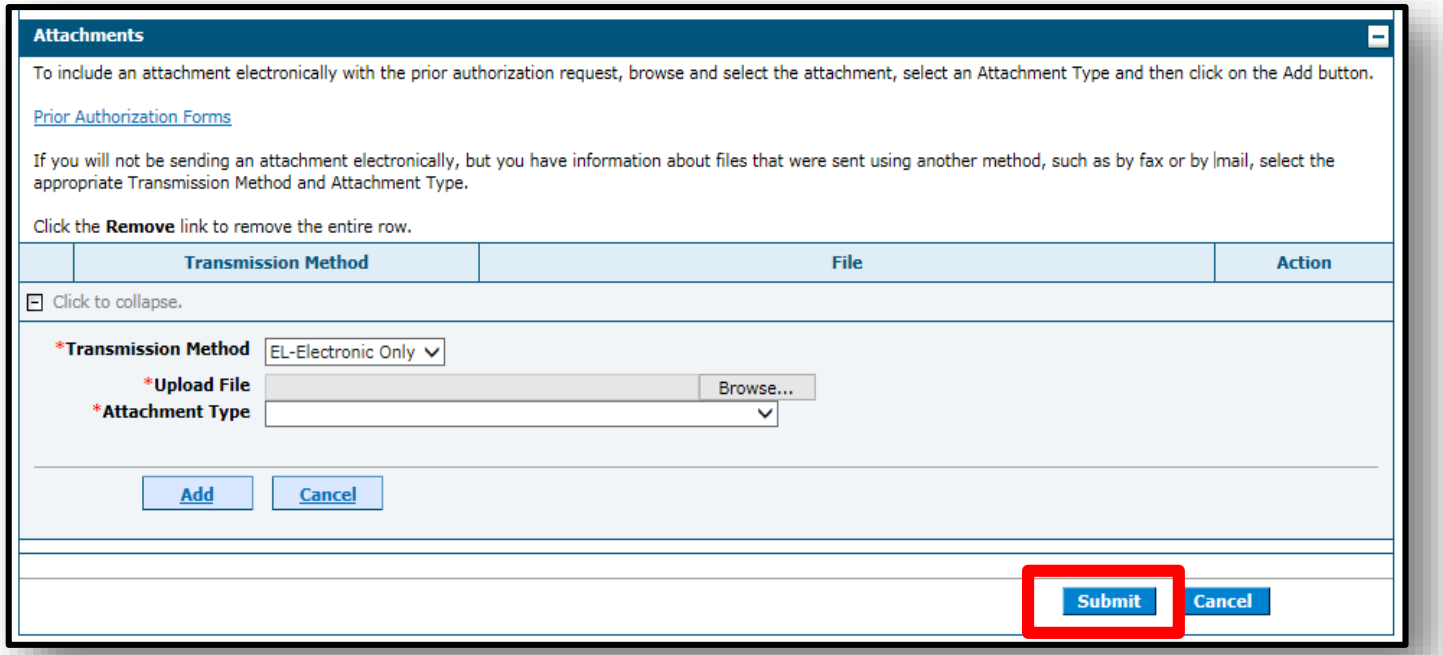
Uploading Attachments, continued
File Upload Naming Convention Guidelines

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

File Upload Naming Convention Examples

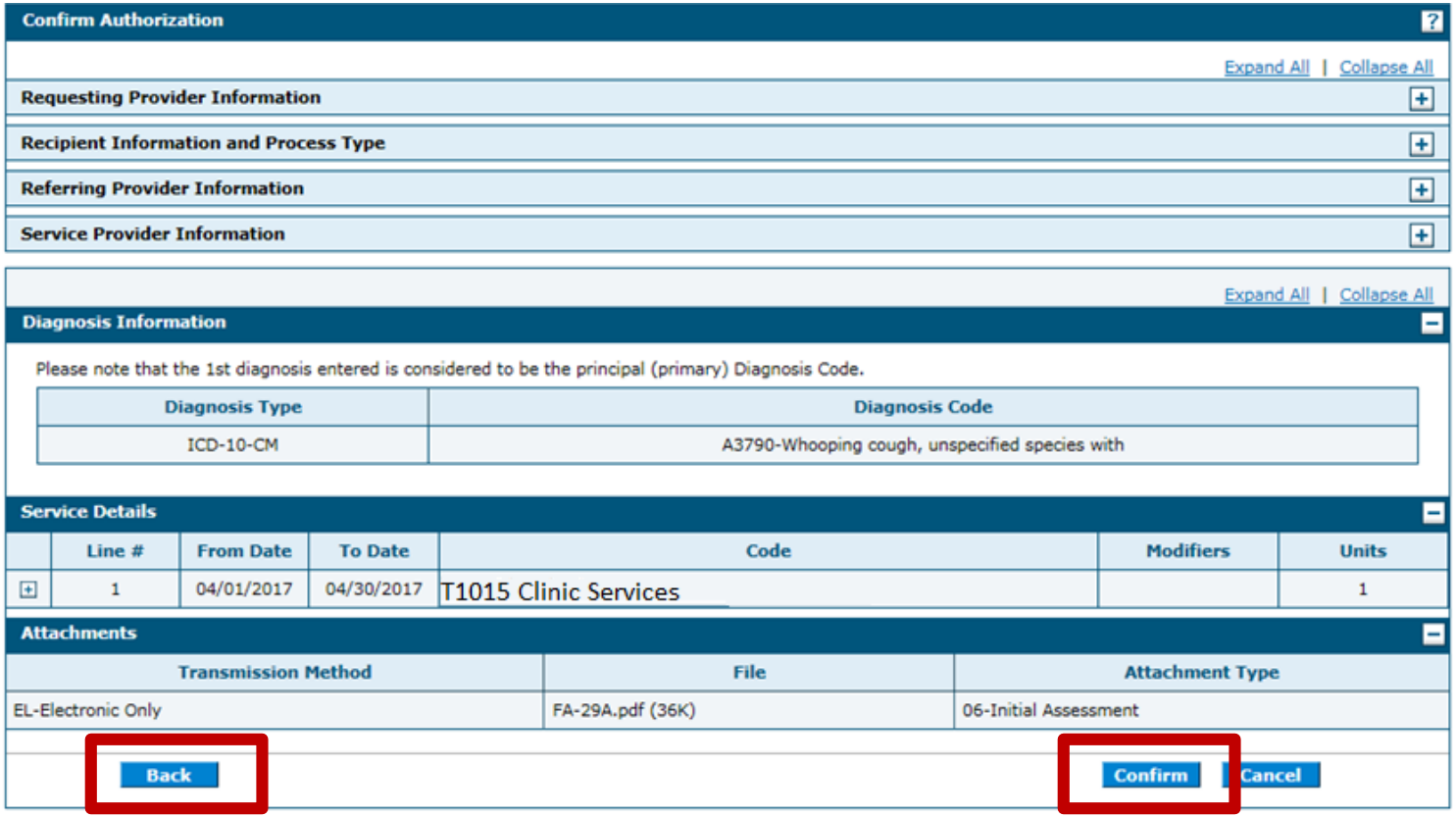
Form Name	
Correct	**Incorrect**
FA-1	
FA-1_MaryPoppins.pdf	MaryPoppins_FA1.pdf
FA-1B	
FA-1B_MaryPoppins.pdf	MaryPoppins_FA-1B.pdf

Submitting a Prior Authorization



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

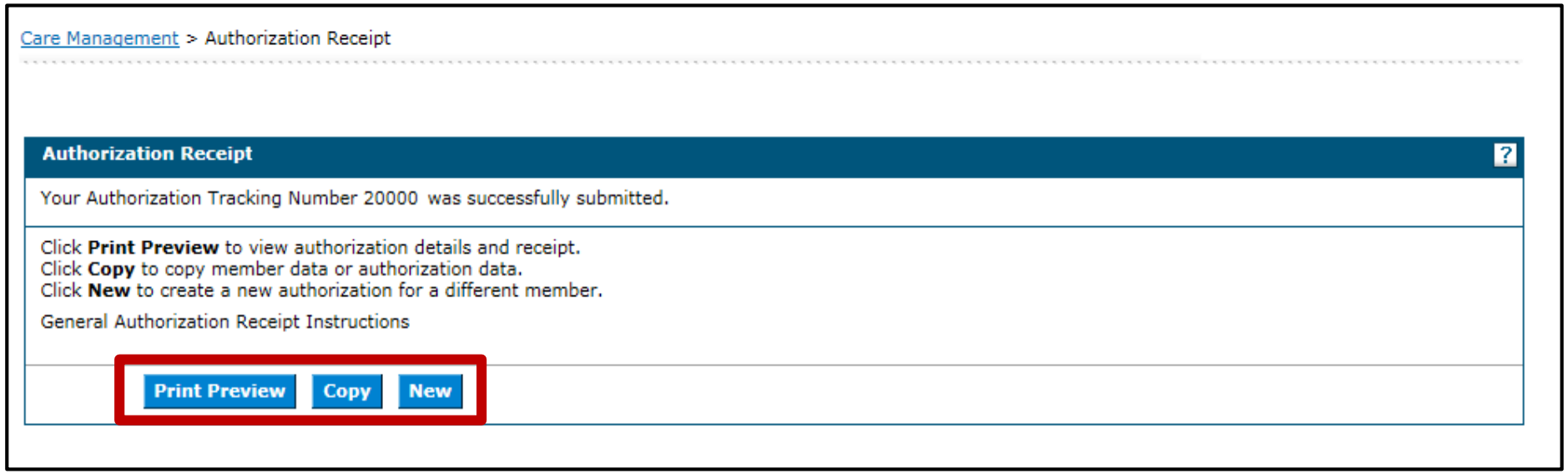
Finalizing a Prior Authorization



Review the information for accuracy:

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

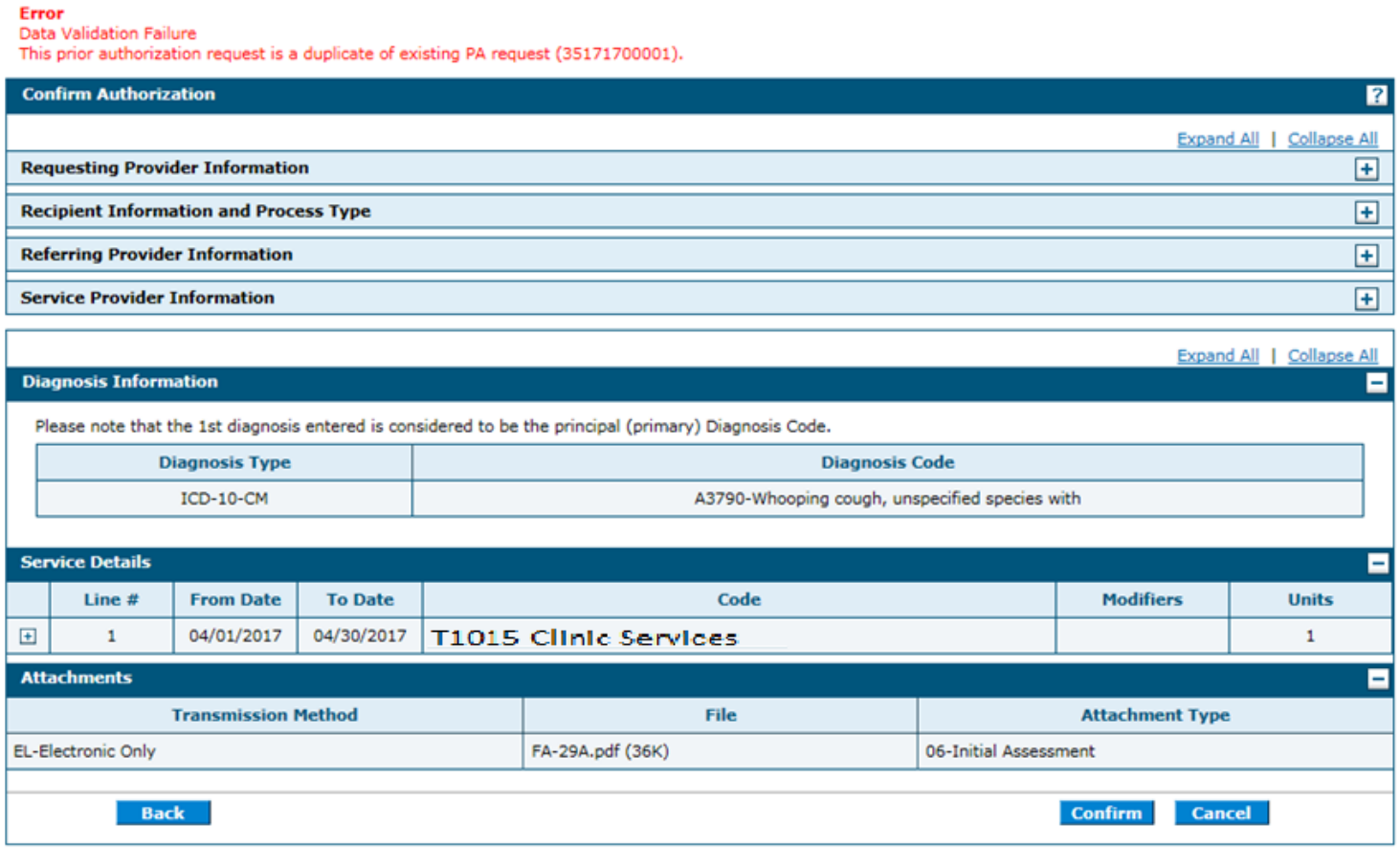
Authorization Successfully Submitted



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

Example of an Unsuccessful Authorization

– Duplicate service lines that already exist on another PA for the same recipient



Error
Data Validation Failure
This prior authorization request is a duplicate of existing PA request (35171700001).

Confirm Authorization

Expand All | Collapse All

Requesting Provider Information

Recipient Information and Process Type

Referring Provider Information

Service Provider Information

Expand All | Collapse All

Diagnosis Information

Please note that the 1st diagnosis entered is considered to be the principal (primary) Diagnosis Code.

Diagnosis Type	Diagnosis Code
ICD-10-CM	A3790-Whooping cough, unspecified species with

Service Details

	Line #	From Date	To Date	Code	Modifiers	Units
⊞	1	04/01/2017	04/30/2017	T1015 Clinic Services		1

Attachments

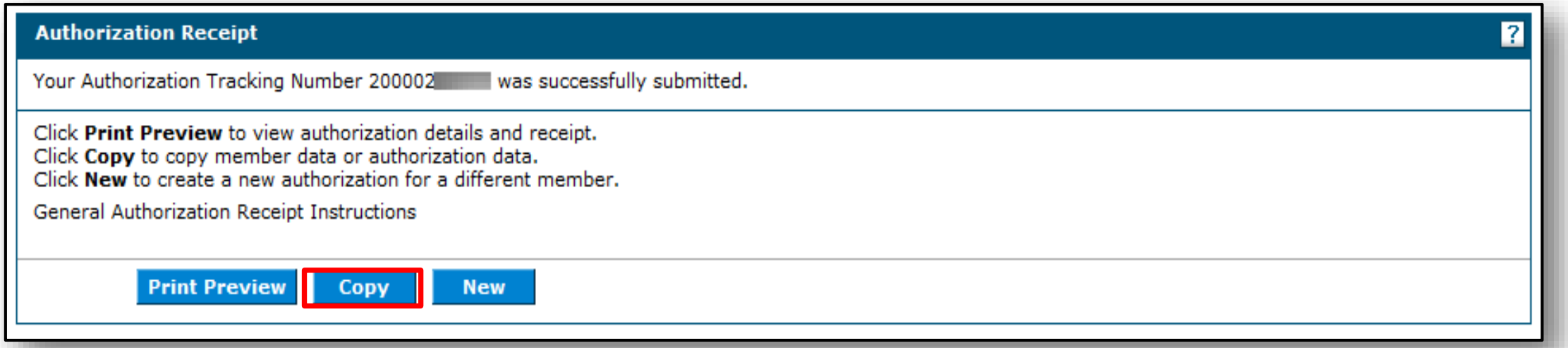
Transmission Method	File	Attachment Type
EL-Electronic Only	FA-29A.pdf (36K)	06-Initial Assessment

Back Confirm Cancel

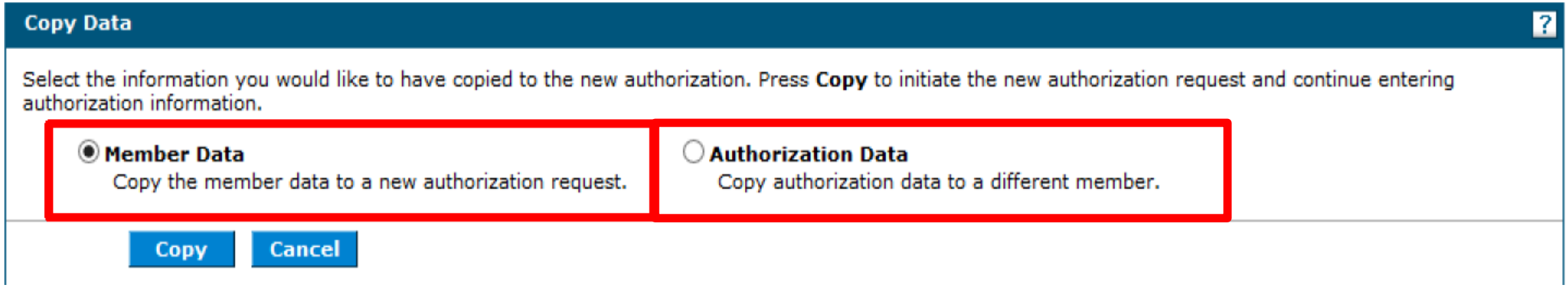
Copying an Authorization

Copying an Authorization

– A PA request can be copied, either for the same recipient or the same service, from the Authorization Receipt screen once the original PA request has been successfully submitted



Copying an Authorization, continued
Member or Authorization Data



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

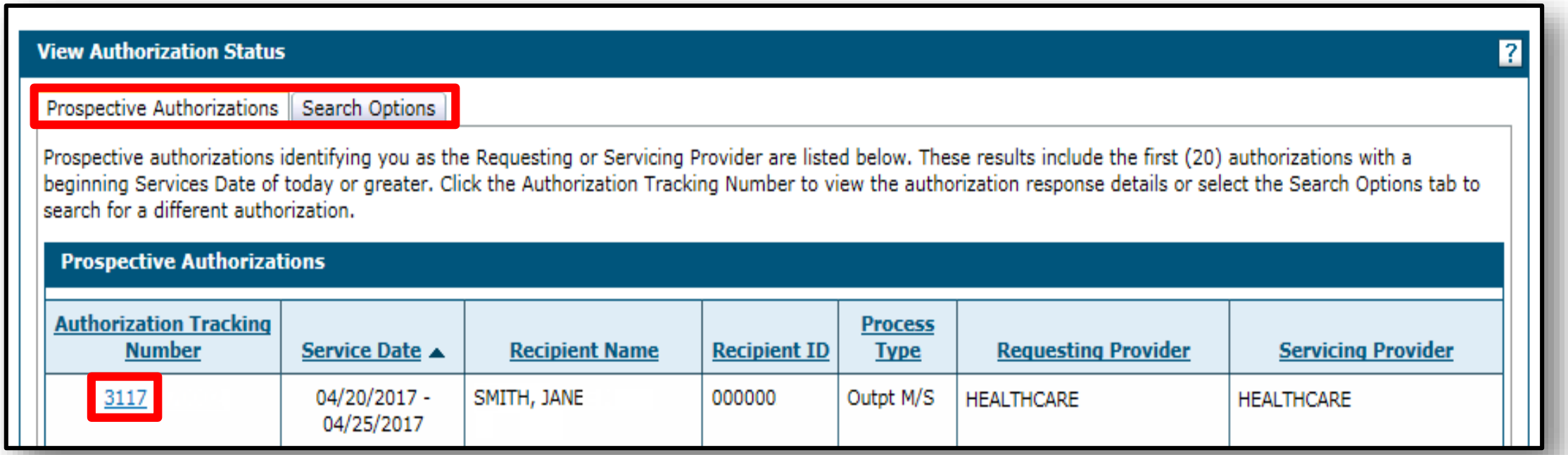
- Copy a PA request by service in order to submit a PA request for similar services but for a different recipient

Viewing Authorizations

View Status of Authorization

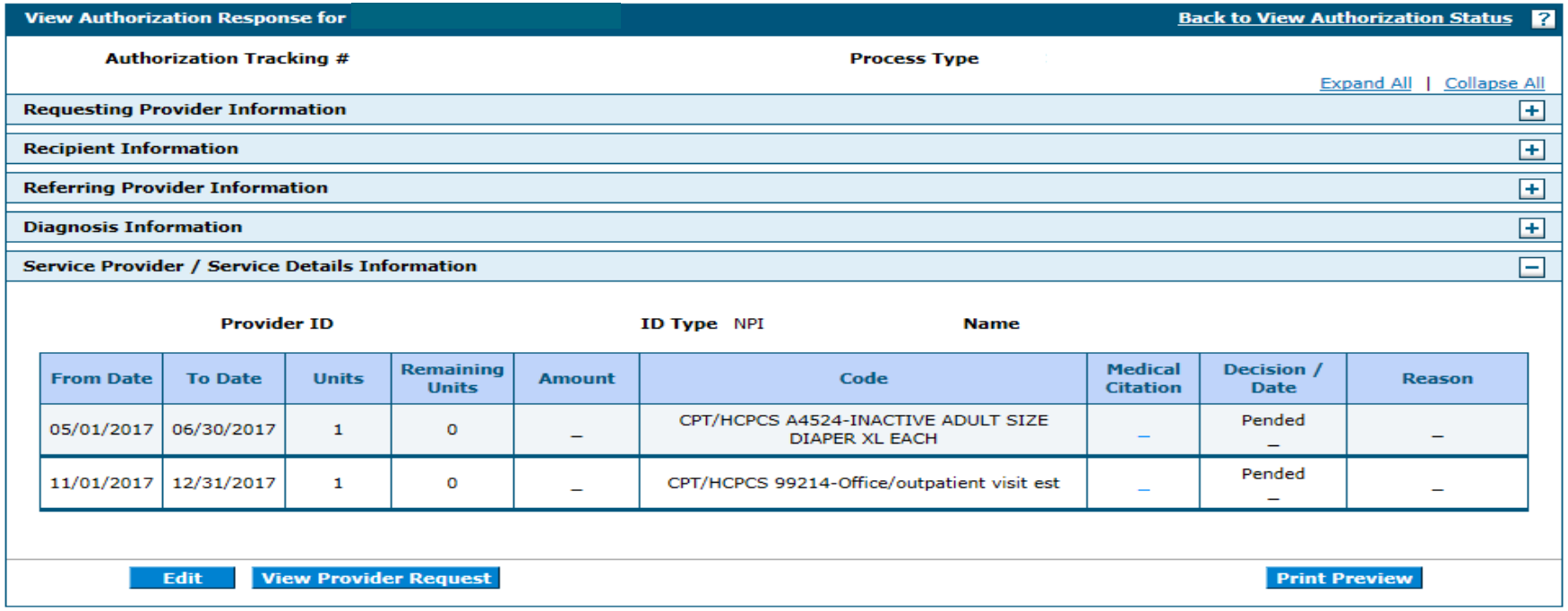
– Hover over the Care Management tab from the top tool bar and select “View Authorization Status” from the sub-menu or select Care Management from the top tool bar and click “View Status of Authorizations” from the Authorizations menu

Viewing Authorizations, continued



- Prospective Authorizations and Search Options tabs will be displayed
- Prospective Authorizations displays PAs by either the requesting or servicing provider
- Search Options allows a search by either recipient or provider information
- To view the details of an authorization, click the blue, underlined “ATN” link

Viewing Authorizations, continued


View Authorization Response for [redacted] Back to View Authorization Status ?

Authorization Tracking # Process Type

Expand All | Collapse All

Requesting Provider Information +

Recipient Information +

Referring Provider Information +

Diagnosis Information +

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
05/01/2017	06/30/2017	1	0	_	CPT/HCPCS A4524-INACTIVE ADULT SIZE DIAPER XL EACH	_	Pended _	_
11/01/2017	12/31/2017	1	0	_	CPT/HCPCS 99214-Office/outpatient visit est	_	Pended _	_

Edit View Provider Request Print Preview

- The ATN is the same as the PA number
- If a claim is submitted before the PA is approved, the claim will deny
- The PA status always defaults to “Pended” until a determination is complete

Viewing Authorizations, continued

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	View	Not Certified 02/21/2013	–
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

- Under the Decision/Date field:
  - Certified in Total – The PA request was approved.
  - *Not* Certified – The PA was not approved.
  - Certified in Partial – The PA was approved but only for a specific amount that is different than what was requested.
- Under the Reason field:
  - Disposition pending review — The PA request is still in process, which appears when the PA request is in “Pended” status.

Viewing Authorizations, continued

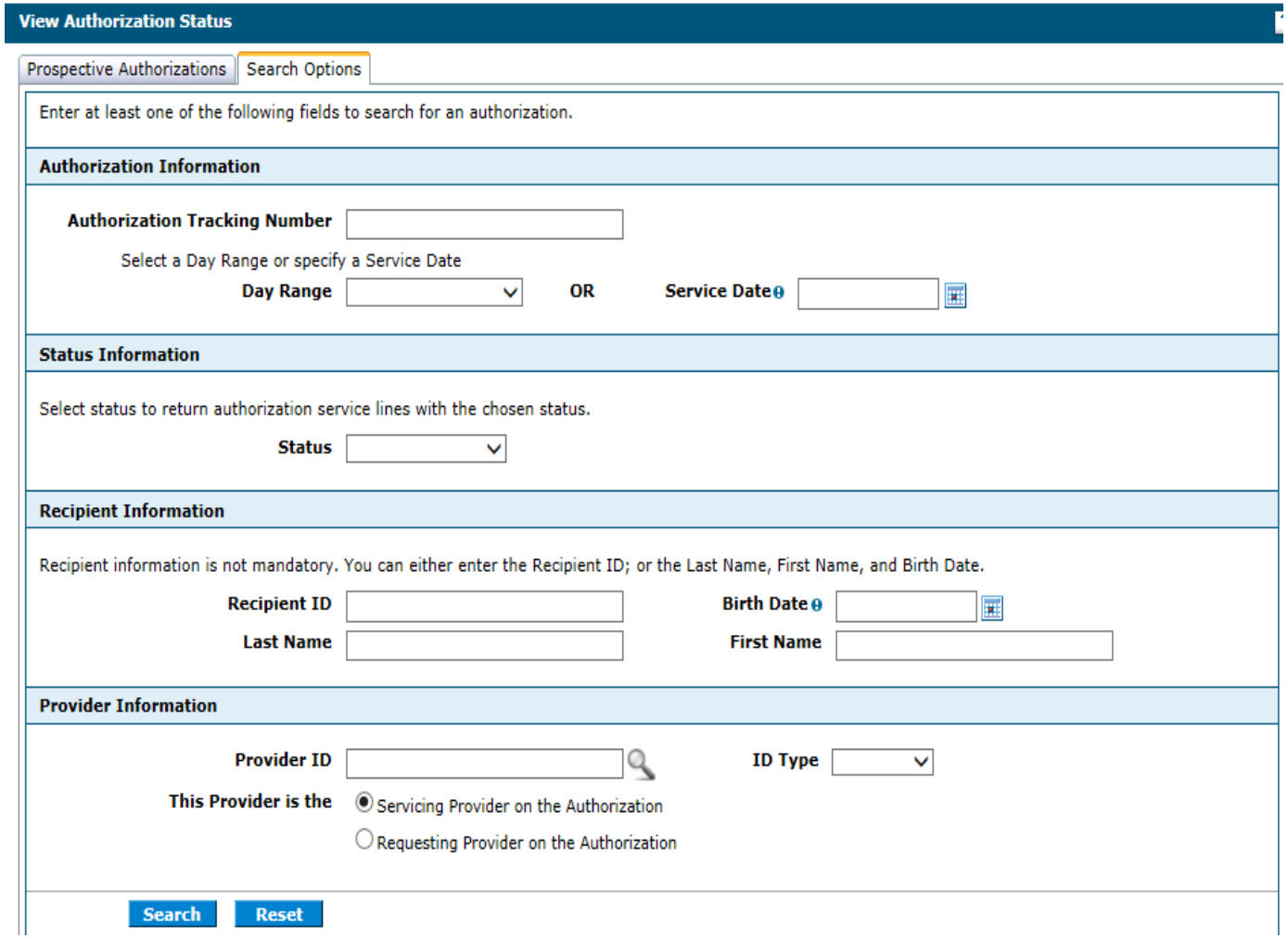
From Date	To Date	Units	Remaining Units	Amount	Code	Medical Citation	Decision / Date	Reason
02/17/2013	02/17/2013	3	0	–	Revenue 0121-R&B-2 BED-MED-SURG-GYN	Hide	Not Certified 02/21/2013	–
Medical Citation 7002 - Information provided does not support medical necessity as defined by Nevada Medicaid. **Notes 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

- Remaining Units/Days **–** The amount counts down as claims are processed. A dash indicates that a claim is not processed for the authorization.
- The Medical Citation field indicates if additional information is needed for all authorizations (including denied). Click “View” to see the details and clinical notes provided by Nevada Medicaid or click “Hide” to collapse the information panel.
- PA requests submitted through the Provider Web Portal are viewable. Faxed authorizations may limit the amount of information that is viewable (summary, status of request).

Searching Authorization Status

Searching Authorization Status, continued



To search for a PA, enter at least one of the following:

- Enter the Authorization Tracking Number
- Select the Day Range from the drop-down list
- Enter the Service Date

Or

Recipient's ID number **or** the recipient's Last name, First name and Date of Birth

Or

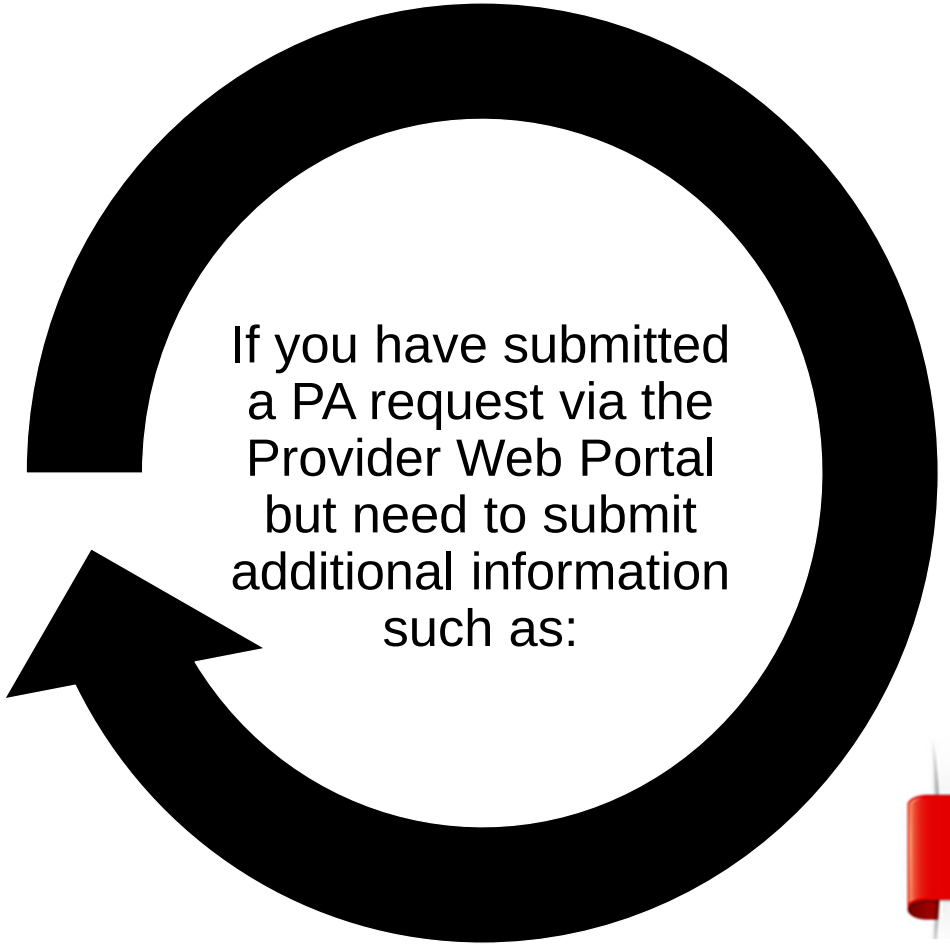
- Provider's NPI and ID Type
- Indicate Servicing or Referring Provider

Click "Search"

- Search results will display at the bottom of the screen

Submitting Additional Information

How to Submit Additional Information



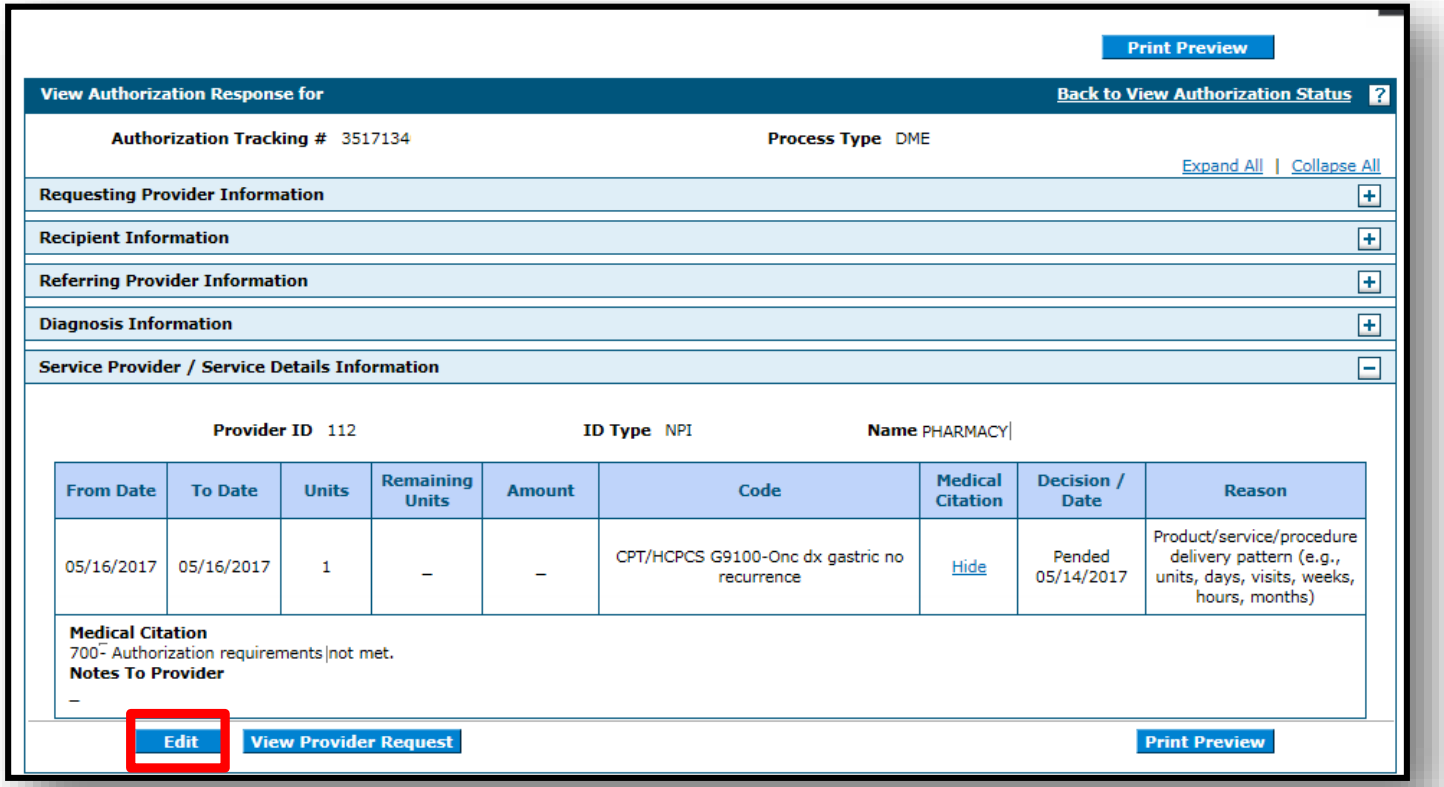
- Requests for additional services
- Attachments that were not submitted with the original PA submission
- An FA-29 Prior Authorization Data Correction Form

Use the approved naming convention when uploading attachments. For instance, use “Form Name” as the prefix, FA-XX.

How to Submit Additional Information, continued

Resubmission Process

- Search for the PA using the View Authorization Status search page
- Click the “ATN” in the Search Results grid
- Click “Edit” on the View Authorization Response page
- The PA is re-opened, and new diagnosis codes, service details, and/or attachments can be added



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

How to Submit Additional Information, continued

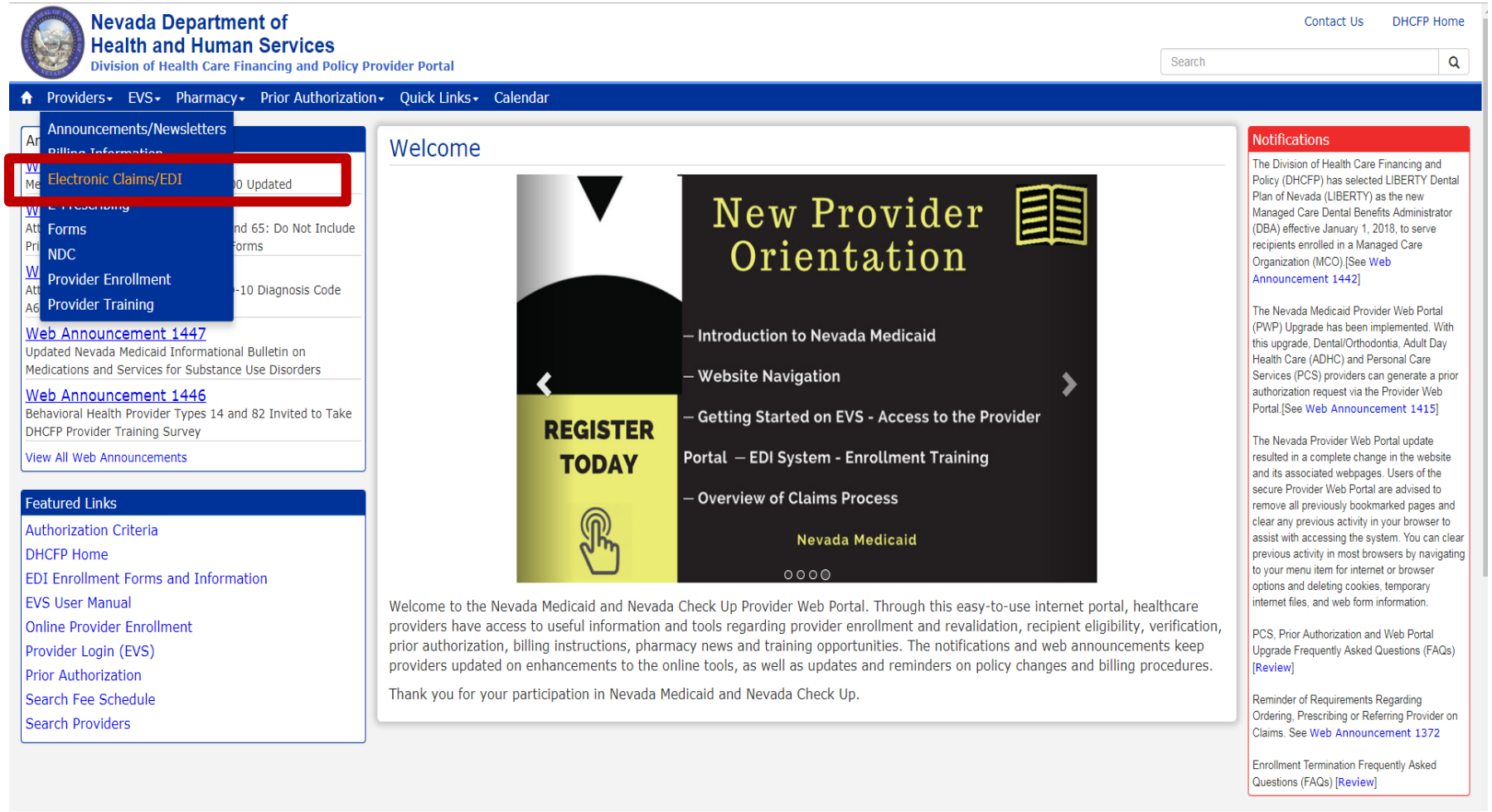
FA-29	Prior Authorization Data Correction Form
FA-29A	Request for Termination of Service
FA-29B	Prior Authorization Reconsideration Request

- 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.

EDI Information

Locating the EDI Page



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

EDI Enrollment Forms

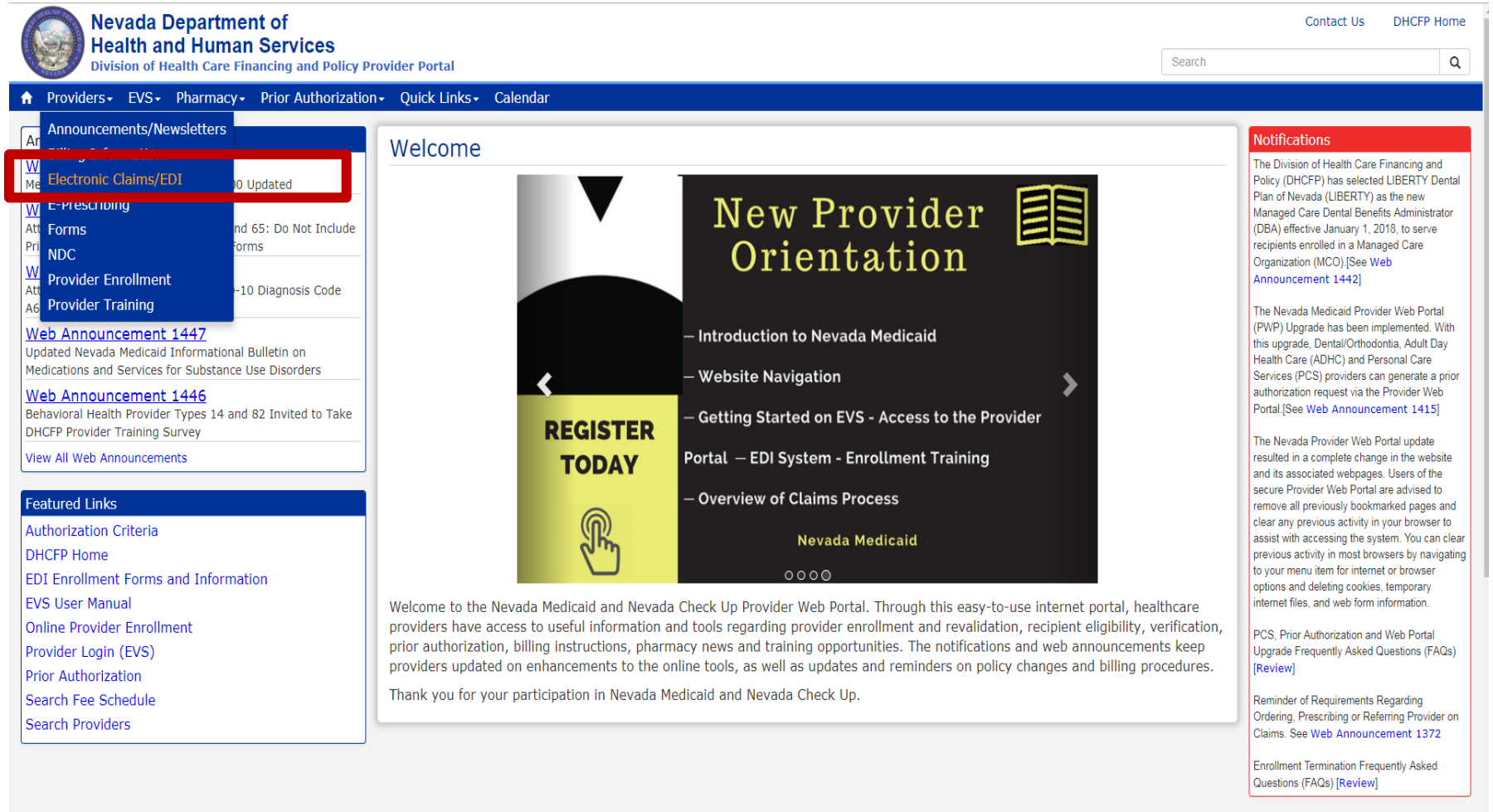
EDI Enrollment Forms

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

Form Number	Title
FA-35	Electronic Transaction Agreement for Service Centers
FA-36	Service Center Operational Information
FA-37	Service Center Authorization
FA-39	Payerpath Enrollment

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

Locating the EDI Companion Guides



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

Locating the EDI Companion Guides, continued

EDI Companion Guides

Title	Date
Transaction 270/271 - Health Care Eligibility Inquiry and Response	February 2015
Transaction 271U – Unsolicited Transaction – HIPAA Version 5010	February 2013
Transaction 277U - Unsolicited 277 Claims Status Response - HIPAA Version 5010	October 2012
Transaction 820 - Health Care Premium Payment - HIPAA Version 5010	October 2012
Transaction 834 - Benefit Enrollment and Maintenance - HIPAA Version 5010	October 2012
Transaction 835 - Health Care Payment/Advice	February 2015
Transaction 837D - Dental Health Care Claim - HIPAA Version 5010	October 2015
Transaction 837I - Institutional Health Care Claim - HIPAA Version 5010	October 2015
Transaction 837P - Professional Health Care Claim - HIPAA Version 5010	October 2015

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

- EDI Companion Guides are located at the bottom of the webpage

Common DME Claim Denial Codes and Resolutions

Edit 0157: Approved Authorization Not on File

This Edit Code sets when a claim is submitted to Nevada Medicaid and the code requires a prior authorization.

Verify that a prior authorization has been requested from and approved by Nevada Medicaid. Do not submit a claim before the prior authorization has been approved.

If the Claim is still being denied, verify that all claim fields are filled out properly with the use of the CMS-1500 Claim Form Instructions located on the Billing Information webpage. If you believe the claim was submitted correctly with valid information and the claim was denied in error, you may appeal the denied claim.

Edit 0967: Procedure Code not Payable with Diagnosis Entered

This Edit Code sets when a claim is submitted to Nevada Medicaid with a HCPCS Code in the T series/range and the Diagnosis Code is not valid. If billing with a HCPCS Code in the T series/range, Diagnosis Codes should be 30011, 307.6, 307.7, 599.84, 625.6, 787.6 or in the range of 788.00-788.99.

If the claim is still being denied, verify that all claim fields are filled out properly with the use of the CMS-1500 Claim Form Instructions located on the Billing Information webpage. If you believe the claim was submitted correctly with valid information and the claim was denied in error, you may appeal the denied claim.

Resources

Additional Resources

- Forms: https://www.medicaid.nv.gov/providers/forms/forms.aspx
- EVS General Information: https://www.medicaid.nv.gov/providers/evsusermanual.aspx
- Secure EVS Web Portal: https://www.medicaid.nv.gov/hcp/provider/Home/tabid/135/Default.aspx
- Billing Manual and Guides: https://www.medicaid.nv.gov/providers/BillingInfo.aspx
- Medicaid Services Manual: http://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSM/MSMHome/

DHCFP Contact Information:

Contact Form: http://dhcfp.nv.gov/Contact/ContactUsForm/

Contact Nevada Medicaid

Contact Us — Nevada Medicaid Customer Service

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

Prior Authorization Department: 800-525-2395

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

Thank You