Psychiatric Hospital, Inpatient (Provider Type 13) Prior Authorization Training

Nevada Medicaid Provider Training

2018

Objectives

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- Recipient Eligibility
- Utilizing the Electronic Verification System (EVS)
- Retrospective Authorizations
- Retrospective Clinical Documentation
- Medicare Eligibility
- Submission Guidelines
- Prior Authorization - Initial Reviews
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- Clinical Documentation
- Skilled Days
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- Prior Authorization Data Correction Form (FA-29)
- Discharge Planning
- Residential Treatment Center (RTC) Referrals

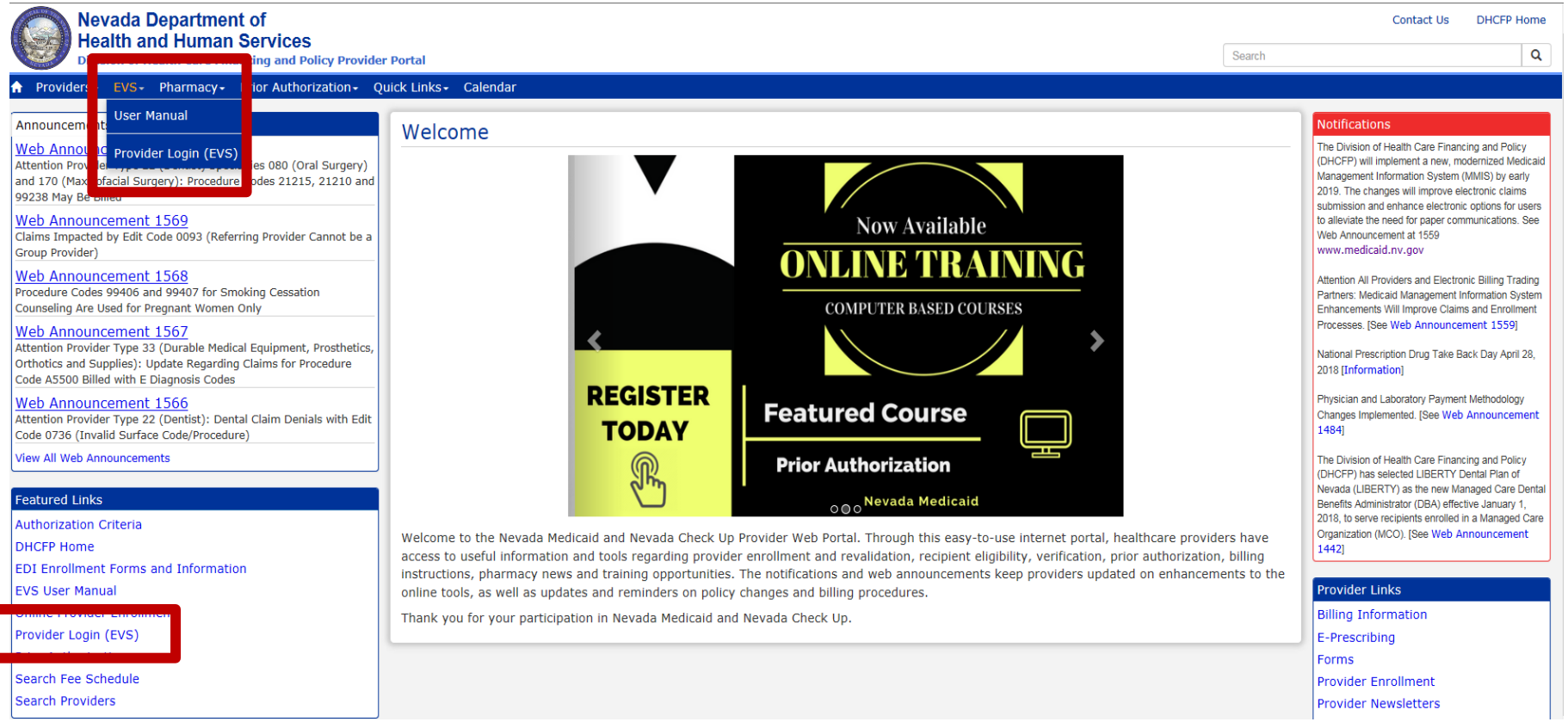
Recipient Eligibility

Recipient Eligibility Tips

- Verify recipient eligibility frequently and at least weekly during a hospital stay.
- Utilize the Electronic Verification System (EVS) to verify recipient eligibility.
- If a recipient's eligibility ends during the course of a hospital stay, a portion of the request will be denied. It is important to check recipient eligibility daily if the recipient remains in the hospital.
- If an individual is admitted while being 20 years of age, then turns 21 during their stay, the recipient is eligible for services until they no longer meet medical necessity or until they turn 22 years of age.
- Provider type 13 may only provide services to recipients who are younger than 21 years of age or older than 64 years of age.
- An approved authorization does not confirm recipient eligibility or guarantee claims payment.

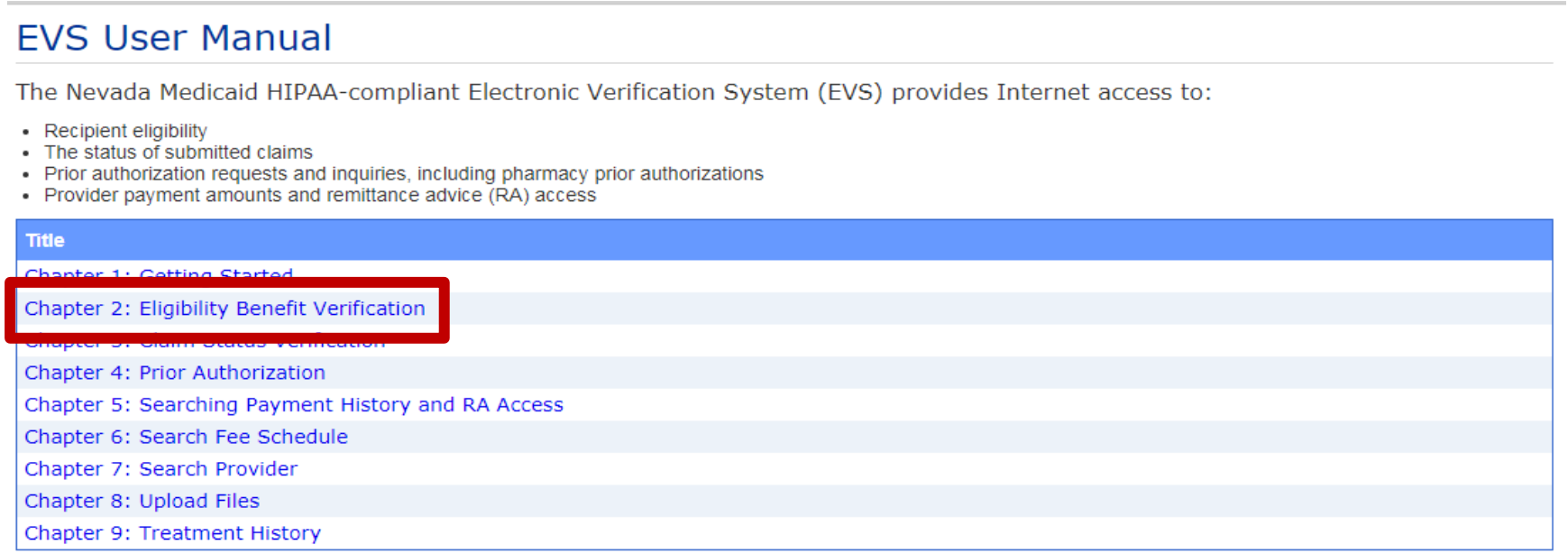
Recipient Eligibility via the Electronic Verification System (EVS)

Utilizing the Electronic Verification System (EVS)



- The EVS can be accessed by highlighting EVS from the top blue toolbar on the Provider Web Portal and selecting “Provider Login (EVS)” or “Provider Login (EVS)” can be selected from the Featured Links list

EVS User Manual



EVS User Manual

The Nevada Medicaid HIPAA-compliant Electronic Verification System (EVS) provides Internet access to:

- Recipient eligibility
- The status of submitted claims
- Prior authorization requests and inquiries, including pharmacy prior authorizations
- Provider payment amounts and remittance advice (RA) access

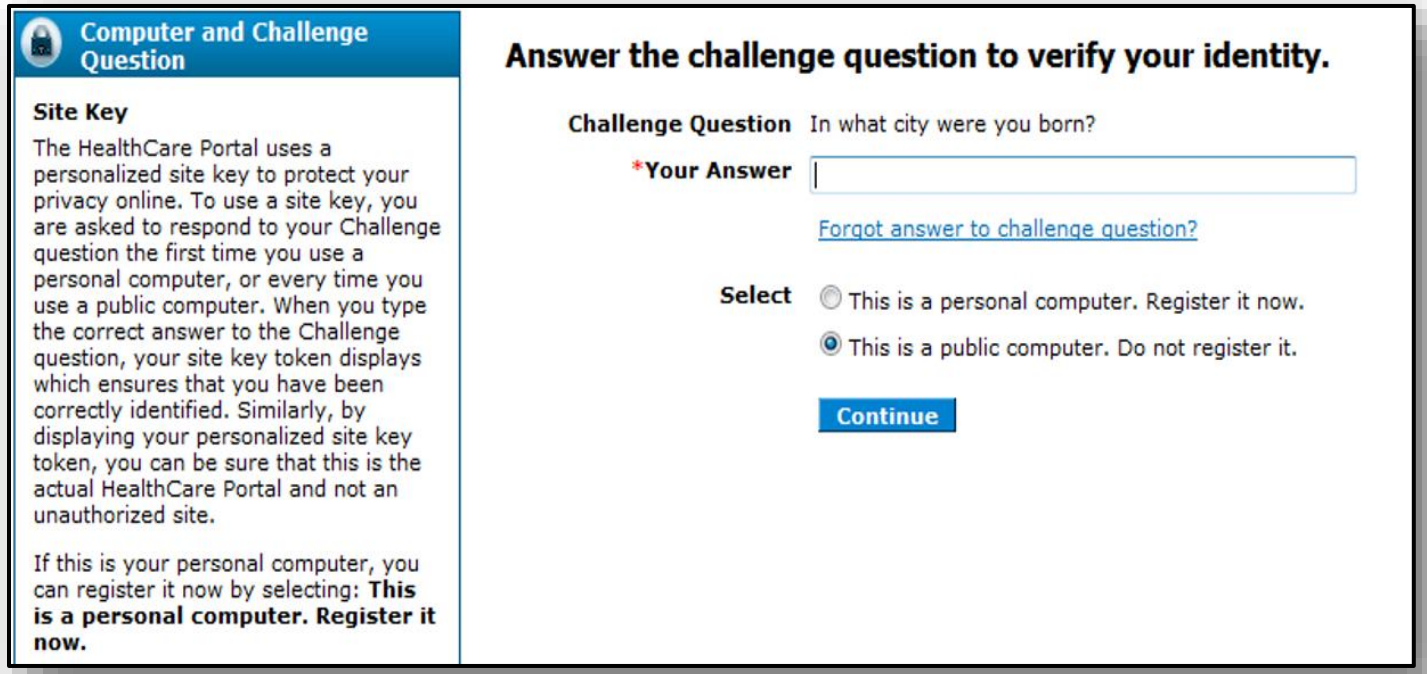
Title
Chapter 1: Getting Started
Chapter 2: Eligibility Benefit Verification
Chapter 3: Claim Status Verification
Chapter 4: Prior Authorization
Chapter 5: Searching Payment History and RA Access
Chapter 6: Search Fee Schedule
Chapter 7: Search Provider
Chapter 8: Upload Files
Chapter 9: Treatment History

- Chapter 2: Eligibility Benefit Verification will allow a provider to input a recipient ID and date range to determine the eligibility of the recipient before rendering any services

Logging in to EVS

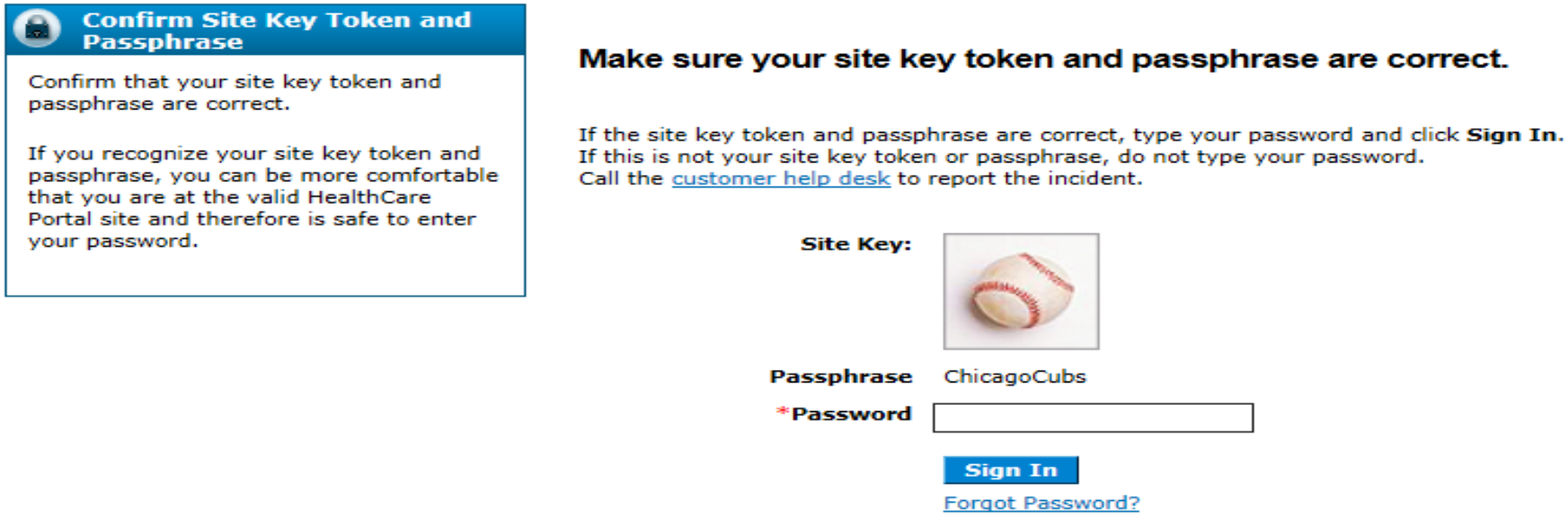
- Step 1: Input User ID
- Step 2: Select “Log In”
- If an account has not been created, select “Register Now” to begin creating a web portal account. See Chapter 1: Getting Started of the EVS User Manual for reference.

Logging in to EVS, 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”

Logging in to EVS, continued

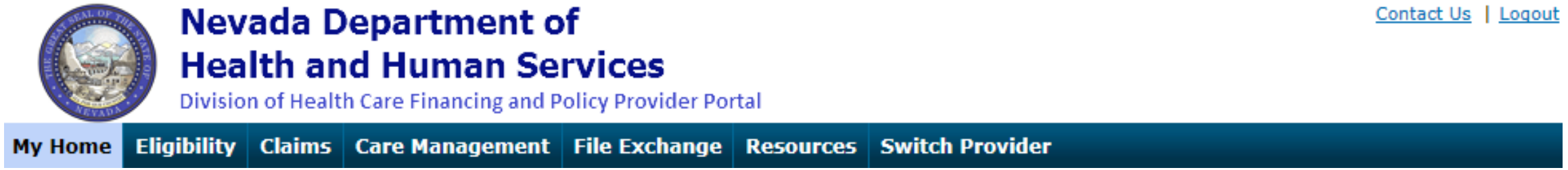


- Confirm that your **site key token** and **passphrase** are correct. If you recognize your site key token and passphrase, you can be assured that you are at the valid Provider Web Portal website and it is safe to enter your password.
- Enter your Password.
- Select “Forgot Password” to start the reset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

EVS Homepage

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

EVS Functionality



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.

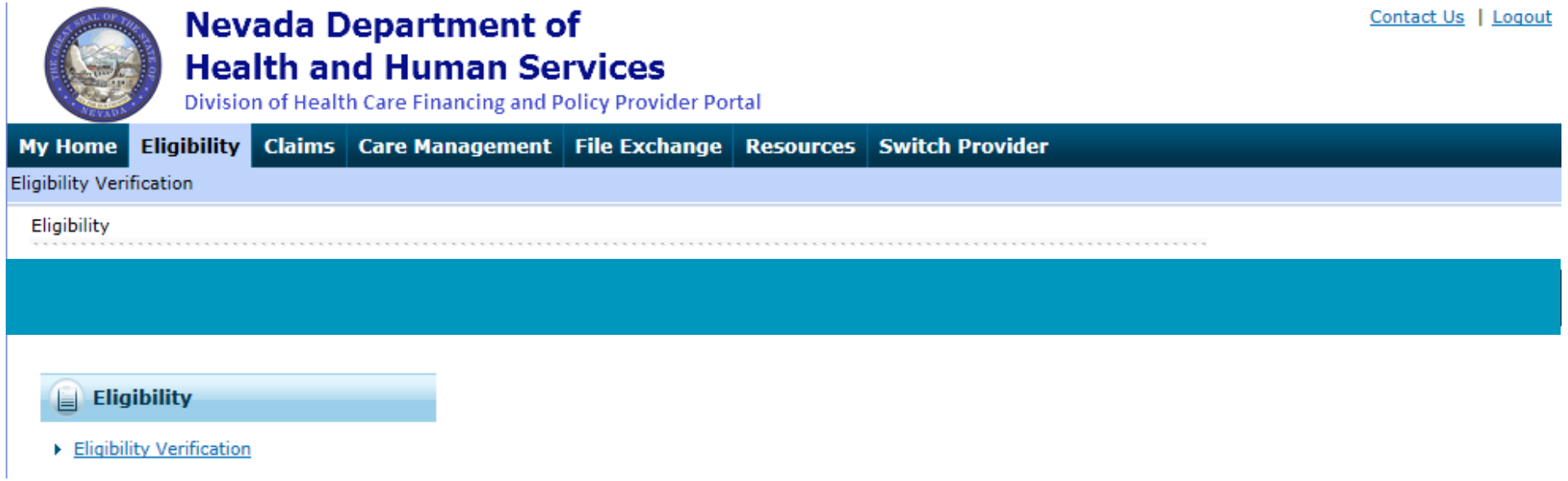
File Exchange

Upload forms online.

Resources

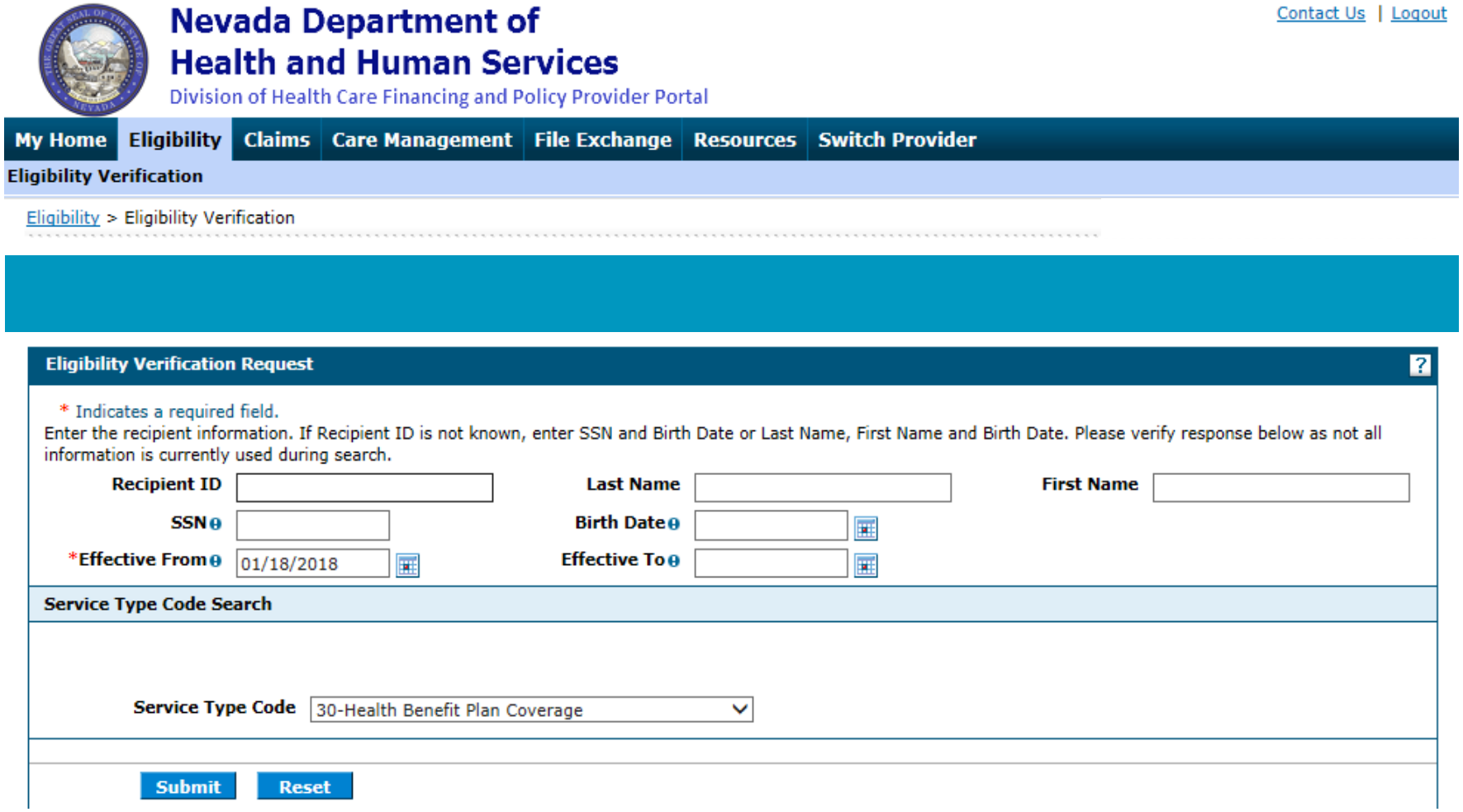
Download forms and documents.

Eligibility Verification



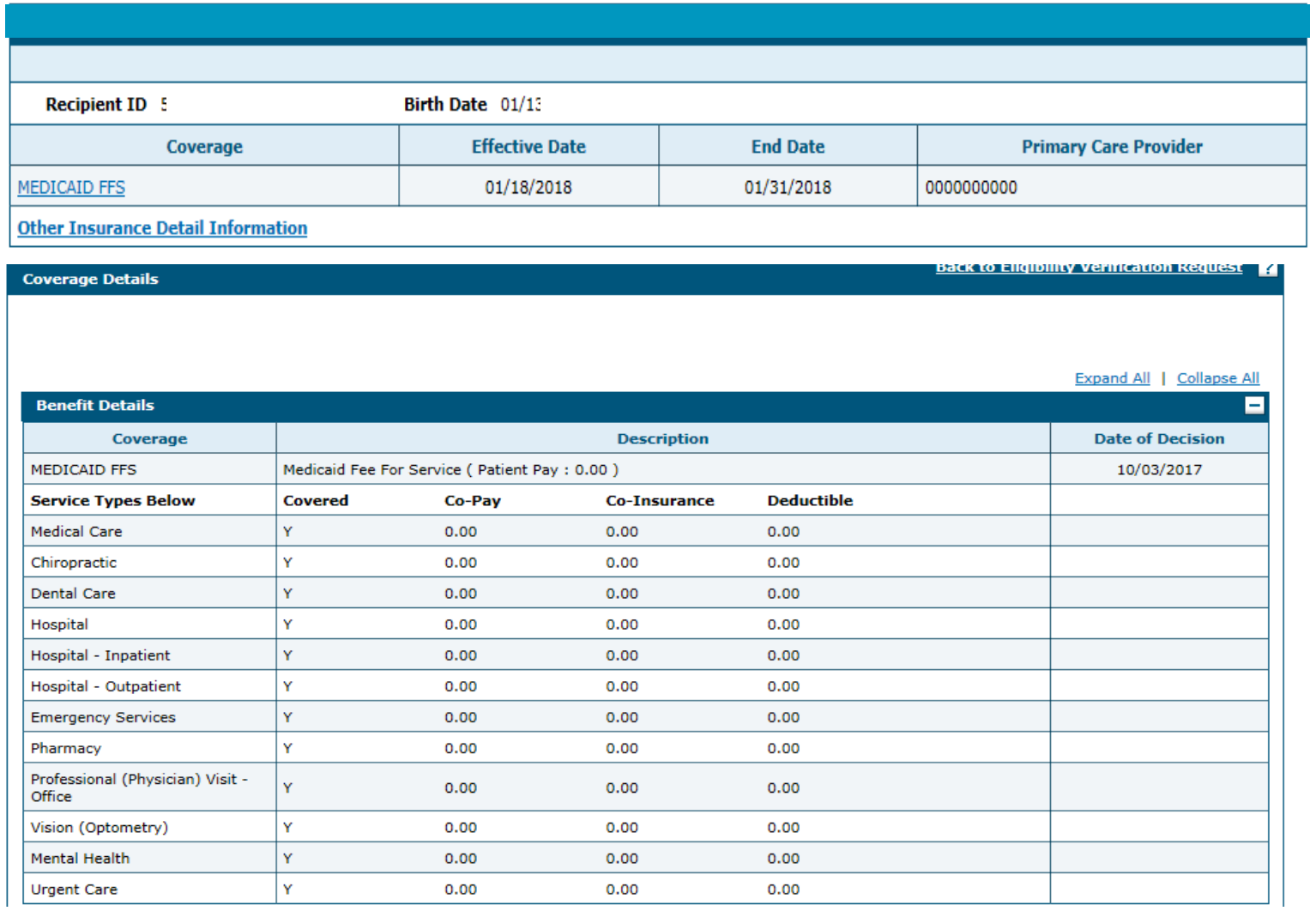
- User can either hover over “Eligibility” or click on the eligibility tab and select “Eligibility Verification” from the sub-menu.

Eligibility Verification, continued



- User will need to input the recipient ID and select the correct “Effective From” date. The “Effective To” date must fall within the same month as the “Effective From” date.
- User will then need to select the appropriate Service Type Code
- Select “Submit”

Eligibility Verification, continued



Recipient ID 5 **Birth Date** 01/13

Coverage	Effective Date	End Date	Primary Care Provider
MEDICAID FFS	01/18/2018	01/31/2018	0000000000

Other Insurance Detail Information

Coverage Details Back to Eligibility Verification Request

Expand All | Collapse All

Benefit Details

Coverage	Description				Date of Decision
MEDICAID FFS	Medicaid Fee For Service (Patient Pay : 0.00)				10/03/2017
Service Types Below	**Covered**	**Co-Pay**	**Co-Insurance**	**Deductible**	
Medical Care	Y	0.00	0.00	0.00	
Chiropractic	Y	0.00	0.00	0.00	
Dental Care	Y	0.00	0.00	0.00	
Hospital	Y	0.00	0.00	0.00	
Hospital - Inpatient	Y	0.00	0.00	0.00	
Hospital - Outpatient	Y	0.00	0.00	0.00	
Emergency Services	Y	0.00	0.00	0.00	
Pharmacy	Y	0.00	0.00	0.00	
Professional (Physician) Visit - Office	Y	0.00	0.00	0.00	
Vision (Optometry)	Y	0.00	0.00	0.00	
Mental Health	Y	0.00	0.00	0.00	
Urgent Care	Y	0.00	0.00	0.00	

- Eligibility information will populate below the Search fields. User can click on the Coverage to view the details.
- For this example, recipient is only eligible for Medicaid FFS and the coverage details are then displayed.
- See Chapter 2 of the EVS User Manual for more coverage code information.

Retrospective Authorizations

Retrospective Authorizations

- If the recipient becomes eligible during their stay, providers must request a retrospective authorization utilizing the Inpatient Mental Health Prior Authorization Request (FA-12) or the Inpatient Mental Health Concurrent Review Request (FA-14).
- If a recipient is currently a patient at the hospital, the provider has 10 business days from the eligibility date of decision to submit the retrospective review.
- If the recipient has discharged prior to the eligibility date of decision, the provider has 90 calendar days to submit their retrospective review.
- When submitting a retrospective authorization, it must be attached to the original prior authorization number which included specific dates of service that were denied for loss of eligibility, when the recipient's eligibility is reinstated (retrospective)

Retrospective Authorizations, continued

- Use FA-12 or FA-14. With either form, select “Retrospective Authorization” and fill out all other necessary fields.
  - The forms can be located on the Providers Forms webpage at www.medicaid.nv.gov
  - All forms are fillable forms
  - All forms can be saved to a desktop for convenient uploading into the Provider Web Portal

Prior Authorization Forms

All prior authorization forms are for completion and submission by current Medicaid providers only.

Form Number	Title
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
FA-3	Inpatient Rehabilitation Referral/Assignment
FA-4	Long Term Acute Care Prior Authorization
FA-6	Outpatient Medical/Surgical Services Prior Authorization Request
FA-7	Outpatient Rehabilitation and Therapy Services Prior Authorization Request
FA-8	Inpatient Medical/Surgical Prior Authorization Request
FA-8A	Induction of Labor Prior to 39 Weeks and Scheduled Elective C-Sections
FA-9	Ocular Services or Medical Nutrition Therapy Services Prior Authorization Request
FA-10A	Psychological Testing
FA-10B	Neuropsychological Testing
FA-10C	Developmental Testing
FA-10D	Neurobehavioral Status Exam
FA-11	Outpatient Mental Health Request
FA-11A	Behavioral Health Authorization
FA-11D	Substance Abuse/Behavioral Health Authorization Request
FA-11E	Applied Behavior Analysis (ABA) Authorization Request
FA-11F	Autism Spectrum Disorder (ASD) Diagnosis Certification for Requesting Initial Applied Behavior Analysis (ABA) Services
FA-12	Inpatient Mental Health Prior Authorization
FA-13	Residential Treatment Center Concurrent Review
FA-13A	RTC Therapeutic Home Pass Form
FA-14	Inpatient Mental Health Services Concurrent Review Request
FA-15	Residential Treatment Center Prior Authorization

Retrospective Documentation

Retrospective Documentation

- When submitting for a retrospective review, please only provide pertinent clinical information that would substantiate medical necessity.
- Voluminous clinical data will not be reviewed and will cause delays in the processing of a request.
- Level of Care (LOC) and dates of service must be clearly documented. Note that Nevada Medicaid will not reimburse for date of discharge).
- Admission and discharge summaries by the physician are recommended along with a concise summary of symptoms, behaviors and treatment interventions that have occurred every 5-7 days.

Medicare Eligibility

Medicare Eligibility

- When submitting a request for a recipient with Medicare Eligibility (Part A), you must include a copy of the Medicare Catastrophic Coverage Act (MECCA) form or other qualifying documentation that demonstrates that the recipient's Medicare days have been exhausted.
- If Medicare Part A days have not been exhausted, a prior authorization is not needed as the provider would be instructed to bill Medicare Part A.
- If Medicare denies a stay due to exhausted benefits and no prior authorization was obtained, the provider may submit a retrospective request and mark that it is a retrospective review for Medicare.
- The retrospective review must be submitted within 30 days of receipt of the Medicare notification or the explanation of benefits (EOB).
- It is recommended that Medicare be billed as soon as possible after the recipient is discharged.

Submission Guidelines

Submission Guidelines

- Initial requests (form FA-12) must be submitted no later than 1 business day after admission.
- Concurrent requests (form FA-14) must be submitted by the anticipated date of discharge of the current/existing authorization period or the next business day if this falls on a non-business day.
- If a concurrent request is not received within the appropriate time frame, a second authorization period, if clinically appropriate, can begin on the date a concurrent authorization is received.
- Providers are advised not to wait to request a concurrent authorization based on a pending appeal or if the prior treatment period is pending information.
- Nevada Medicaid will not pay for unauthorized days between the end date of the first authorization period and the begin date of the second authorization period.

Prior Authorization Information

Prior Authorization Information, Initial Review

- All requests should be made using form FA-12 and uploaded to the Provider Web Portal.
- Requests for the initial stay may not exceed 7 days, except for retrospective reviews.
- A CASII/LOCUS acuity level of at least 6 is required for hospital admission.
- A Certificate of Need (CON) must be signed and dated by the physician and must be included with FA-12.
- FA-12 must include an individualized treatment plan with active participation by the recipient and their family, when applicable.
- Documentation must include all behavioral health services that have been attempted prior to admission, including name of the provider, services rendered and dates of service.

Prior Authorization Information, Concurrent Review

- All requests should be made using form FA-14 and uploaded to the Provider Web Portal.
- Requests for concurrent stay may not exceed 7 days, except for retrospective reviews.
- Each prior authorization must stand on its own; therefore, 2-3 sentences regarding why the recipient was initially admitted is recommended. Generally this is documented under justification for continued services.
- As the recipient's acuity level is at least 6, after the initial dates of service there should not be any unspecified diagnoses or remaining rule out diagnoses.

Clinical Documentation

Clinical Documentation

- All information on the appropriate FA form, including start dates and number of days requested, must be consistent with the information entered into the Provider Web Portal. If any of the information is not consistent, there will be a delay in the processing of the request.
- Type all information into the appropriate form as illegible forms will not be processed.
- Any information that must be brought to the reviewer's attention should be placed prominently at the beginning or the front of the request; for example, this information can be placed on a cover sheet or the top of the FA form.
- While viewing a prior authorization in the Provider Web Portal, review the Medical Citation field as additional information may be requested from Nevada Medicaid.
- ICD-10 diagnosis codes must be utilized to include the correct code and narrative disorder.

Clinical Documentation, continued

– While viewing a prior authorization in the Provider Web Portal, review the Medical Citation field as additional information may be requested from Nevada Medicaid. This will also allow the user to view the status of the prior authorization.

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

Skilled Days

Skilled Days

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

Skilled Days, continued

- Skilled Days will be denied if the recipient was not at an acute inpatient level of care facility at least 1 day immediately preceding the request for skilled days.
- Skilled Days will be denied if a recipient, family member or physician refuse to cooperate with the discharge plan or refuse appropriate placement.
- Skilled Days will be denied if the provider fails to submit evidence of comprehensive discharge planning.

Appeals

Appeals, Peer-to-Peer Review

- Denied dates of service cannot be requested as a concurrent review. Denied dates of service may only be appealed.
- A peer-to-peer is appropriate if based on the clinical rationale for the denial/reduction the provider would like clarified. A peer-to-peer review is a one-on-one telephone conversation between the Nevada Medicaid physician and the provider/physician or an appointed clinical designee.
- When a request has been modified or denied by the physician, the provider may request a peer-to-peer within 10 business days of the date on the Notice of Decision (NOD) letter. Note that the peer-to-peer does not have to occur within the 10 business days. A peer-to-peer review does not extend the 30-day deadline for submitting a reconsideration review. Please refer to Web Announcement 474 at www.medicaid.nv.gov to schedule a peer-to-peer.
- If there is new information introduced at the peer-to peer-review, the session will be terminated and the provider will be advised to submit a reconsideration review.

Appeals, Reconsideration Review

- A reconsideration request is a one-time review of denied/modified services.
- If there is new or additional clinical information to be presented, then the reconsideration review should be used. The reconsideration review must be submitted within 30 days of the date on the Notice of Decision (NOD) letter.
- An alternate physician reviewer will base the reconsideration determination on the previously submitted clinical documentation and the new/additional clinical information provided in the request for reconsideration.

Appeals, Reconsideration Review, continued

- Use the original FA-12 or FA-14 to request a reconsideration and mark “reconsideration” at the top of the form.
- If the FA-12 or FA-14 is submitted as an initial or concurrent review, the request will be rejected as a duplicate request.
- Change the start date and number of days requested to reflect only those days that were denied by the physician.
- Clearly indicate the new or additional information that is being documented with either a cover sheet or near the front of the request being sent to Nevada Medicaid.

Data Correction Form (FA-29) Submission

Data Correction Form (FA-29) Submission

- When submitting a Prior Authorization Data Correction Form (FA-29), please be sure to reference the prior authorization number to which the information should be attached.
- Please understand that if you are wanting to change a date of service (add or delete), Nevada Medicaid is unable to process this request if the units on that specific line of service have already been adjudicated by claims.
- Please ensure that you submit the FA-29 with the correct National Provider Identifier (NPI).
- Always include detailed information, a contact name and direct telephone number of a person who can answer questions regarding submission of the FA-29.

Discharge Planning

Discharge Planning

- Discharge planning should begin on the date of admission.
- As the hospital stay continues, there should be evidence of comprehensive discharge planning. This would include where the recipient is going to be discharged and what services will be recommended for the recipient after discharge. Please be specific regarding the type of locations and the types of service.
- There must be a legible and comprehensive psychiatric evaluation completed prior to the recipient's discharge to facilitate coordination of care between the hospital and other agencies.

Residential Treatment Center (RTC) Referrals

RTC Referrals

- A legible and comprehensive psychiatric evaluation is required prior to RTC admission.
- Prior to making an out-of-state RTC referral, please ensure that all in-state resources have been exhausted, including outpatient (OP) services and in-state RTC's.
- If there is a plan for the recipient to "transfer" to another RTC, the accepting RTC must document the services they can provide that the current RTC cannot provide.
- Recipients transferring to an out-of-state RTC must have a caseworker/case manager from the State of Nevada for oversight of services.
- Should the recipient have developmental delays that would prohibit them from rehabilitative services, those delays must be documented and include the most recent psychological or neuropsychological testing completed.

RTC Referrals, continued

- If referring a recipient to an RTC, document and provide explanations regarding any unspecified diagnosis codes.
- If the recipient is too violent to be placed in an enclosed and locked area with their peers, this is considered an exclusion to RTC placement.
- If the recipient has a developmental delay, including intellectual delays, this may be exclusionary to RTC placement based on the fact that the RTC level of care is rehabilitative.
- The recipient must have the ability to benefit from the rehabilitative RTC milieu and intensive OP services.

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 Login: 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/

Contact Nevada Medicaid

Contact Us — Nevada Medicaid Customer Service

- Nevada Medicaid Prior Authorization Department: 800-525-2395
- Customer Service Call Center: 877-638-3472 (Monday through Friday 8 a.m. to 5 p.m. Pacific Time)
- Nevada Provider Training: NevadaProviderTraining@dxc.com

Thank You