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

Nevada Medicaid Provider Training

2019

Objectives

Objectives

- Recipient Eligibility
- Recipient Eligibility via the Electronic Verification System (EVS)
- Medicare Eligibility
- Submission Guidelines
- Prior Authorization (PA) Processes
- Prior Authorization (PA) Information
- Retrospective Authorizations and Documentation
- Clinical Documentation
- Skilled Days
- Submit a Prior Authorization via the EVS secure Provider Web Portal
- Discharge Planning
- Residential Treatment Center (RTC) Referrals and Psychiatric Evaluations
- Coverage and Limitations
- Resources
- Contact Nevada Medicaid

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.

- **Provider type 13 may only provide services to recipients who are younger than 21 years of age or older than 64 years of age.**

- 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.

- An approved authorization does not confirm recipient eligibility or guarantee claims payment.

Recipient Eligibility via the Electronic Verification System (EVS)

Navigating the Provider Web Portal (PWP)

Once registered, users may access their accounts from the PWP "Home" page by:

1. Entering the **User ID.**
2. Clicking the **Log In** button.

Navigating the PWP, continued

Computer and Challenge Question

Site Key

The HealthCare Portal uses a personalized site key to protect your privacy online. To use a site key, you are asked to respond to your Challenge question the first time you use a personal computer, or every time you use a public computer. When you type the correct answer to the Challenge question, your site key token displays which ensures that you have been correctly identified. Similarly, by displaying your personalized site key token, you can be sure that this is the actual HealthCare Portal and not an unauthorized site.

If this is your personal computer, you can register it now by selecting: **This is a personal computer. Register it now.**

Answer the challenge question to verify your identity.

Challenge Question In what city were you born?

3 ***Your Answer** [   ]

Forgot answer to challenge question?

4 **Select** ○ This is a personal computer. Register it now.
⦿ This is a public computer. Do not register it.

5 **Continue**

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

3. Type in their answer to the **Challenge Question** to verify identity.
4. Choose whether log in is on a **personal computer** or **public computer.**
5. Click the **Continue** button.

Navigating the PWP, continued

The user will continue providing identity verification:

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

NOTE: If information is incorrect, contact the help desk by clicking the **Customer help desk** link.

Navigating the PWP, continued

Once the user has provided identity verification and entered their password, the "My Home" page will display.

From there, the user will need to:

9. Verify all provider information located on the left margin of the screen.

NOTE: If this provider information is incorrect, users should contact the Help Desk by clicking the **Contact Us** link on the right side of this page.

Navigating the PWP, continued

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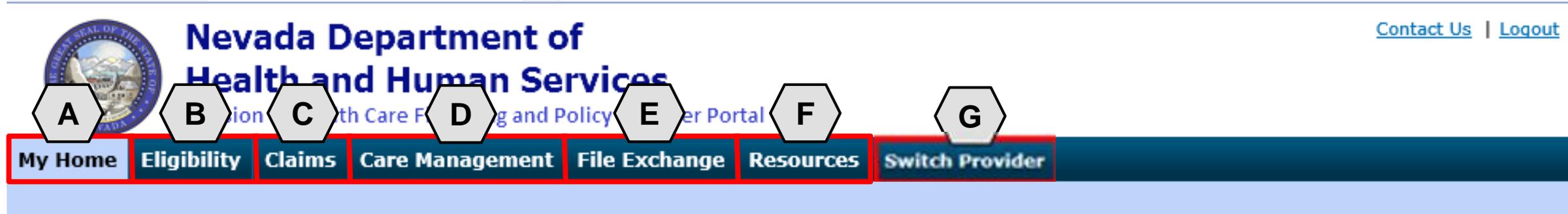
The tabs at the top of the page provide users quick access to helpful pages and information:

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**: 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.

Searching for a Member's Benefit Eligibility

1. Hover over **Eligibility.**
2. Select **Eligibility Verification.**

Searching for a Member's Benefit Eligibility, continued

3. Enter a **Recipient ID**; **SSN** and **Birth Date**; or **First Name**, **Last Name**, and **Birth Date**

4. Select the **Effective From** and **To** date range (defaults to current date)

5. Select the **Service Type Code**

6. Click the **Submit** button

NOTE: Click the **Reset** button to clear the fields and start a new search.

Viewing a Member's Benefit Details

Eligibility Verification Request ⁇

* Indicates a required field.
Enter the recipient information. If Recipient ID is not known, enter SSN and Birth Date or Last Name, First Name and Birth Date. Please verify response below as not all information is currently used during search.

Recipient ID		**Last Name**		**First Name**	
SSN 🛈		**Birth Date** 🛈			
*Effective From 🛈	02/01/2019	**Effective To** 🛈	02/28/2019		

Service Type Code Search

Service Type Code [30-Health Benefit Plan Coverage ▾]

[Submit] [Reset]

Eligibility Verification Information for ⬛⬛⬛ **from 02/01/2019 to 02/28/2019**

Recipient ID   **Birth Date**

Coverage	Effective Date	End Date	Primary Care Provider	Date of Decision
Medicaid Fee For Service	02/01/2019	02/28/2019	0000000000	07/31/2018
Managed Care Organization	02/01/2019	02/28/2019	ANTHEM BLUE CROSS AND BLUE SHIELD	
Dental Benefit Administrator	02/01/2019	02/28/2019	LIBERTY DENTAL PLAN OF NEVADA INC (1013434810)	
Non Emergency Transportation	02/01/2019	02/28/2019	MEDICAL TRANSPORTATION MANAGEMENT INC (1134260078)	

Other Insurance Detail Information

The results display below the **Eligibility Verification Request** panel. Verify the recipient displayed matches the recipient being searched.

Information in this panel lists all eligible coverage from Managed Care Organizations (MCOs) and a link to other health coverage (OHC) and third-party insurance details.

NOTE: The system will display an error message if the member is not found or does not have eligible benefits during the given effective date range.

Viewing a Member's Benefit Details, continued

Eligibility Verification Request   ?

* Indicates a required field.
Enter the recipient information. If Recipient ID is not known, enter SSN and Birth Date or Last Name, First Name and Birth Date. Please verify response below as not all information is currently used during search.

| **Recipient ID** | | **Last Name** | | **First Name** | |

| **SSN** ⓘ | | **Birth Date** ⓘ | | |

| ***Effective From** ⓘ | 02/01/2019 | **Effective To** ⓘ | 02/28/2019 | |

Service Type Code Search

Service Type Code 30-Health Benefit Plan Coverage ▼

[Submit] [Reset]

Eligibility Verification Information for . **from 02/01/2019 to 02/28/2019**

Recipient ID   **Birth Date**

Coverage	Effective Date	End Date	Primary Care Provider	Date of Decision
Medicaid Fee For Service	02/01/2019	02/28/2019	0000000000	07/31/2018
Managed Care Organization	02/01/2019	02/28/2019	ANTHEM BLUE CROSS AND BLUE SHIELD	
Dental Benefit Administrator	02/01/2019	02/28/2019	LIBERTY DENTAL PLAN OF NEVADA INC (1013434810)	
Non Emergency Transportation	02/01/2019	02/28/2019	MEDICAL TRANSPORTATION MANAGEMENT INC (1134260078)	

Other Insurance Detail Information

〈1〉

From the **Eligibility Verification Request** panel:

1. Select any of the **Coverage** links to view details about all available coverage benefits.

NOTE: The Effective and End Dates in the results panel match the range used in the search criteria. Users can also view the Date of Decision.

Viewing a Member's Benefit Details, continued

Print Preview

Coverage Details   **Back to Eligibility Verification Request** ?

Coverage Details for   from 02/01/2019 to 02/28/2019

Verification Response ID

Expand All | Collapse All

Benefit Details   ─

Coverage	Description	Effective Date	End Date	Date of Decision
Medicaid Fee For Service	The Medicaid Program is a State administered, federal grant-in-aid program. Its purpose is to help meet the cost of medical services of those individuals receiving public assistance payments, and those individuals and families with low income. The program objective is to provide a broad range of medical and related services to assist individuals to attain or retain an optimal level of health care. Medicaid is jointly funded by the federal and state governments and is administered by the State.	02/01/2019	02/28/2019	07/31/2018

Copayment Details	+
Coinsurance Details	+
Deductible Details	+
Managed Care Assignment Details	+
Living Arrangement Details	+
Demographic Details	+

After clicking any of the coverage links, the "Coverage Details" page displays, listing details about each coverage benefit in sections.

The available sections will depend on the types of coverage the member has.

Most sections initially display as hidden. Click the (+) symbol to expand the section and view the details or click the **Expand All** link to expand all sections.

NOTE: Log the **Verification Response ID** for future reference. The ID identifies this specific eligibility verification instance.

Viewing a Member's Benefit Details, continued

Expand All | Collapse All

Benefit Details					−
Coverage	**Description**	**Effective Date**	**End Date**	**Date of Decision**	
Medicaid Fee For Service	The Medicaid Program is a State administered, federal grant-in-aid program. Its purpose is to help meet the cost of medical services of those individuals receiving public assistance payments, and those individuals and families with low income. The program objective is to provide a broad range of medical and related services to assist individuals to attain or retain an optimal level of health care. Medicaid is jointly funded by the federal and state governments and is administered by the State.	02/01/2019	02/28/2019	07/31/2018	

Copayment Details		−
Coverage	**Service Type**	**Amount**
Medicaid Fee For Service	Medical Care	$0.00
Medicaid Fee For Service	Dental Care	$0.00
Medicaid Fee For Service	Chiropractic	$0.00
Medicaid Fee For Service	Hospital	$0.00
Medicaid Fee For Service	Hospital - Inpatient	$0.00
Medicaid Fee For Service	Urgent Care	$0.00
Medicaid Fee For Service	Emergency Services	$0.00
Medicaid Fee For Service	Pharmacy	$0.00
Medicaid Fee For Service	Professional (Physician) Visit - Office	$0.00
Medicaid Fee For Service	Vision (Optometry)	$0.00
Medicaid Fee For Service	Mental Health	$0.00
Medicaid Fee For Service	Hospital - Outpatient	$0.00

A

B

A. The **Benefit Details** section will always be available. This section lists all active coverage for the date range and provides descriptions of each coverage type.

B. The **Copayment Details** section lists all copayments that a member could have for services during the date range.

NOTE: Most sections list all applicable service types and their associated amounts or percentages on separate lines. Only a few lines are shown in these examples.

Viewing a Member's Benefit Details, continued

C

Coinsurance Details −

Coverage	Service Type	Percentage
Medicaid Fee For Service	Medical Care	0%
Medicaid Fee For Service	Dental Care	0%
Medicaid Fee For Service	Chiropractic	0%
Medicaid Fee For Service	Hospital	0%
Medicaid Fee For Service	Hospital - Inpatient	0%
Medicaid Fee For Service	Urgent Care	0%
Medicaid Fee For Service	Emergency Services	0%
Medicaid Fee For Service	Pharmacy	0%
Medicaid Fee For Service	Professional (Physician) Visit - Office	0%
Medicaid Fee For Service	Vision (Optometry)	0%
Medicaid Fee For Service	Mental Health	0%
Medicaid Fee For Service	Hospital - Outpatient	0%

C. The **Coinsurance Details** section lists all coinsurance payments that a member could have for services during the date range.

D

Deductible Details −

Coverage	Service Type	Amount
Medicaid Fee For Service	Medical Care	$0.00
Medicaid Fee For Service	Dental Care	$0.00
Medicaid Fee For Service	Chiropractic	$0.00
Medicaid Fee For Service	Hospital	$0.00
Medicaid Fee For Service	Hospital - Inpatient	$0.00
Medicaid Fee For Service	Urgent Care	$0.00
Medicaid Fee For Service	Emergency Services	$0.00
Medicaid Fee For Service	Pharmacy	$0.00
Medicaid Fee For Service	Professional (Physician) Visit - Office	$0.00
Medicaid Fee For Service	Vision (Optometry)	$0.00
Medicaid Fee For Service	Mental Health	$0.00
Medicaid Fee For Service	Hospital - Outpatient	$0.00

D. The **Deductible Details** section lists all deductibles that a member could have for services during the date range.

Viewing a Member's Benefit Details, continued

Managed Care Assignment Details			
Primary Care Provider	**Type**	**Provider Phone**	**Benefit Plan**
ANTHEM BLUE CROSS AND BLUE SHIELD	Health Benefit Plan Coverage	1-999-999-9999	Managed Care Organization
LIBERTY DENTAL PLAN OF NEVADA INC	Health Benefit Plan Coverage	1-999-999-9999	Dental Benefit Administrator
MEDICAL TRANSPORTATION MANAGEMENT INC	Health Benefit Plan Coverage	1-999-999-9999	Non Emergency Transportation
Current MCO and DBA			**NPI/API**
ANTHEM BLUE CROSS AND BLUE SHIELD			
LIBERTY DENTAL PLAN OF NEVADA INC			1013434810
MEDICAL TRANSPORTATION MANAGEMENT INC			1134260078

E. The **Managed Care Assignment Details** section lists information about a member's managed care providers and their contact details

Living Arrangement Details
Patient Liability/Client Obligation: $0.00

Demographic Details
Street Address
City **State** **Zip Code**

F. The **Demographic Details** will always be available. This section lists the member's address.

Viewing a Member's Benefit Details, continued

Print Preview

Coverage Details

Coverage Details for JOHN A SMITH from 02/01/2019 to 02/28/2019

Verification Response ID 1912600009

Expand All | Collapse All

Benefit Details

Coverage	Description	Effective Date	End Date	Date of Decision
Medicaid Fee For Service	The Medicaid Program is a State administered, federal grant-in-aid program. Its purpose is to help meet the cost of medical services of those individuals receiving public assistance payments, and those individuals and families with low income. The program objective is to provide a broad range of medical and related services to assist individuals to attain or retain an optimal level of health care. Medicaid is jointly funded by the federal and state governments and is administered by the State.	02/01/2019	02/28/2019	07/31/2018

Copayment Details

Coinsurance Details

Deductible Details

Managed Care Assignment Details

Living Arrangement Details

Demographic Details

Back to Eligibility Verification Request

When finished reviewing the member's benefit details, the user has the option to print the page by clicking the **Print Preview** button at the top of the page.

The user may also click the **Back to Eligibility Verification Request** link to return to the results page and view third-party details for the member.

Viewing a Member's Third-Party Coverage

Eligibility Verification Request

* Indicates a required field.
Enter the recipient information. If Recipient ID is not known, enter SSN and Birth Date or Last Name, First Name and Birth Date. Please information is currently used during search.

Recipient ID	48317469498	**Last Name**		**First Nan**
SSN		**Birth Date**		
*Effective From	12/05/2018	**Effective To**	12/31/2018	

Service Type Code Search

Service Type Code 30-Health Benefit Plan Coverage ▼

Submit   **Reset**

Eligibility Verification Information for NYEPCPPY KRXOXE from 12/05/2018 to 12/31/2018

Recipient ID 48317469498	**Birth Date** 03/06/1939		
Coverage	**Effective Date**	**End Date**	
Medicaid Fee For Service	12/05/2018	12/31/2018	0000000000
Qualified Medicare Beneficiaries	12/05/2018	12/31/2018	0000000000
Special Low Income Medicare Beneficiaries	12/05/2018	12/31/2018	0000000000

Other Insurance Detail Information

From the results display below the **Eligibility Verification Request** panel, select the **Other Insurance Detail Information** link to view third-party coverage benefits.

Viewing a Member's Third-Party Coverage, continued

Print Preview

Other Insurance Information for HVXQOSDCN I IRAPSEU						Back to Eligibility Verification Request		?
Carrier Name	**Policy ID**	**Group ID**	**Policy Holder**	**Policy Type**	**Coverage Type**	**Primary**	**Effective Date**	**End Date**
HPN HEALTH PLAN OF NEVADA, INC (01091)	15006254801	10000846A001	GXCTBX IRAPSEU	HEALTH	HOSPITALIZATION	Unknown	05/01/2015	12/31/2299
OPTUMRX (09363)	15006254801	10000846A001	GXCTBX IRAPSEU	HEALTH	PHARMACY	Unknown	05/01/2015	12/31/2299

Print Preview

Other Insurance Information for NYEPCPPY KRXOXE	Back to Eligibility Verification Request	?
There is no information available for the Other Insurance. Contact Us for more information.		

NOTE: When there are no benefit records to display, the system provides a message indicating that there is no information available.

After clicking the **Other Insurance Detail Information** link, the system will display any active third-party details available for the effective date range used in the search.

When finished reviewing the member's third-party details, the user has the option to print the page by clicking the **Print Preview** button at the top of the page. Also click the **Back to Eligibility Verification Request** link to return to the results page and view coverage benefit details for the member.

Medicare Eligibility

Medicare Eligibility

– When submitting a request for a recipient with Medicare Eligibility (Part A), 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

– Authorization must be obtained prior to admission by submitting the initial request (form FA-12), with the exception of an emergency admission, in which case, Nevada Medicaid must be notified within one 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 (PA) Processes

Prior Authorization Process

– The admission must be certified by Nevada Medicaid for emergency and non-emergency inpatient psychiatric admissions based on:

  – Medical necessity.

  – Clear evidence of the physician's admission order.

    – The date and time of the order and status of the recipient's admission (i.e., inpatient, observation, same day surgery, transfer to observation, etc.).

  – Recipient meeting Level 6 on the intensity of needs grid (CASII for children/LOCUS for adults).

– The hospital must submit all required documentation, including:

  – Signed and dated physician order reflecting admit date and time.

  – Any other pertinent information requested by Nevada Medicaid.

– Non-emergency admissions not prior authorized by the QIO-like vendor will not be reimbursed by Nevada Medicaid.

Prior Authorization Process, continued

- Transfers and Planned Admissions:

    - For those instances when a physician's order was issued for a planned admission and before the recipient arrives at the hospital:

        - The order must be signed by the physician and indicate the anticipated date of admission.

    - A physician order must also be issued for transfers from another acute care hospital.

- Observations:

    - Observation status cannot exceed a maximum of 48 hours.

    - Begins when the physician issues an observation status order and ends when the recipient is discharged from the hospital.

- A new Admission order must be issued and signed by a physician when a recipient is admitted to inpatient status after discharge from observation status.

Emergency Authorization Process

– Authorization must be obtained prior to admission, with the exception of an emergency admission, in which case Nevada Medicaid must be notified within one business day.

– Emergency inpatient psychiatric admission is defined as meeting at least one of the following:

  – Active suicidal ideation accompanied by a documented suicide attempt or a documented history of a suicide attempt(s) within the past 30 days.

  – Active suicidal ideation within the past 30 days accompanied by physical evidence (ex: a note) or means to carry out the suicide threat (ex: gun, knife, etc.).

  – Documented aggression within the 72-hour period before admission which:

    – Resulted in harm to self, others or property.

    – Manifests as requiring control that cannot be maintained outside an inpatient hospitalization.

    – Is expected to continue without treatment.

During Initial Authorization Period

– The psychiatric assessment, discharge plan and written treatment plan must be initiated, with the attending physician's involvement.

– In addition, when a recipient remains hospitalized longer than seven days the attending physician must document the medical necessity of each additional inpatient day.

– Note: Acute inpatient admissions authorized by Nevada Medicaid don't require any additional authorizations for physician-ordered psychological evaluations and testing:

– The psychologist must list the "Inpatient Authorization Number" on the claim form when billing for services.

Prior Authorization (PA) Information

Prior Authorization (PA) Information, Initial Review

– Requests must be submitted using form FA-12 and uploaded to the Provider Web Portal. The Certificate of Need (CON) is included within this and must be signed by the physician with a current date.

– Prior authorization requests, if medically and clinically appropriate, will be authorized up to seven days, except for retrospective reviews.

– A CASII/LOCUS acuity level of at least 6 is required for hospital admission.

– FA-12 must include an individualized treatment plan with active participation by the recipient and their family (when applicable).

– Documentation must include all outpatient services that have been attempted prior to admission (include name of the provider, specific services and dates of service).

Prior Authorization Information, FA-12

– FA-12 Form is to be used when requesting an Initial Review

– **Section I (Recipient Information)**

    – Fill out all information pertaining to the recipient.

– **Section II (Responsible Party Information)**

    – Fill out if the responsible party **is not** the recipient.

– **Section III (Admitting Facility Information)**

    – Fill out all information pertaining to the Admitting Facility.

– **Section IV (Treatment History)**

    – This section must filled out completely and is continued on Page 2.

Prior Authorization Request
Nevada Medicaid and Nevada Check Up
Inpatient Mental Health

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

REQUEST DATE: _____ /_____ /_____

REQUEST TYPE: ☐ Initial Review   ☐ Reconsideration

☐ Retrospective (For retrospective requests, please indicate the date of eligibility decision, the start date of services, the number of days being requested at the Acute level of care and, *if applicable*, the number of days being requested at the Skilled level of care.)

Date of Eligibility Decision: _____   Start date: _____

Retrospective Acute LOC days: _____   Retrospective Skilled LOC days: _____

NOTES:

I. RECIPIENT INFORMATION

Recipient Name (Last, First, MI):		
Recipient Medicaid ID:		DOB:
Address:		
City:	State:	Zip Code:
Phone:	Date recipient went into DHS Custody:	

Marital Status: ☐ Single   ☐ Married   ☐ Separated   ☐ Divorced   ☐ Widowed

Describe recipient's current living environment, or, if already admitted, describe living environment prior to admission.

☐ Alone   ☐ Foster Home   ☐ Group Home   ☐ With Parent   ☐ Med/Surg Hospital   ☐ With Non-Relative
☐ Psychiatric   ☐ With Relative   ☐ RTC   ☐ With Spouse   ☐ Unknown   ☐ Other:

II. RESPONSIBLE PARTY INFORMATION *(Complete this section when the responsible party is not the recipient.)*

Responsible Party Name:		

Relationship to Recipient: ☐ Court   ☐ Government Agency   ☐ Parents   ☐ Relative   ☐ Other:

Address:		
City:	State:	Zip Code:
County:	Phone:	

III. ADMITTING FACILITY INFORMATION

Name:	NPI:
Address:	

City:	State:	Zip Code:
Telephone Number:	Fax Number:	

IV. TREATMENT HISTORY

Has the recipient had prior inpatient treatment? ☐ No   ☐ Yes *(If yes, enter facilities and service dates below.)*

FA-12
Updated 01/30/2019 *(pv10/01/2015)*

Page 1 of 4

Prior Authorization Information, FA-12, continued

- **Section IV, continued (Treatment History)**

  - Fill out all information pertaining to the recipient.

- **Section V (ICD-10 Diagnosis)**

  - Input appropriate and active ICD-10 diagnosis codes.

- **Section VI (Symptoms and Medications)**

  - List all symptoms that the recipient is experiencing and medications currently and previously being prescribed to the recipient.

Prior Authorization Request
Nevada Medicaid and Nevada Check Up
Inpatient Mental Health

Facility Name	Length of Stay	Facility Name	Length of Stay
1.	to	4.	to
2.	to	5.	to
3.	to	6.	to

Has the recipient had prior outpatient treatment? ☐ No ☐ Yes *(If yes, complete the following lines.)*

Provider Name	Dates of Service	Frequency of Service	Outcome of Service
1.			
2.			
3.			
4.			

Other Placements *(Foster Care, Group Home, Shelter, Detention, Training School, Boot Camp, etc.)*

Facility Name	Length of Stay	Facility Name	Length of Stay
1.	to	4.	to
2.	to	5.	to
3.	to	6.	to

V. ICD-10 DIAGNOSIS

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

VI. SYMPTOMS AND MEDICATIONS

Current symptoms requiring inpatient care: *(include clinical rationale for number of days being requested for review and evaluation of risk)*

Chronic behaviors:

FA-12
Updated 01/30/2019 *(pv10/01/2015)*

Page 2 of 4

Prior Authorization Information, FA-12, continued

– **Section VI, continued (Symptoms and Medications)**

– **Section VII (Requested Treatment)**

   – Select the requested treatment and provide additional details, such as, admission information, length of stay and discharge plan

Prior Authorization Request
Nevada Medicaid and Nevada Check Up
Inpatient Mental Health

Use the lines below to list the recipient's current medications.

Drug Name	Dosage	Purpose	Dates Used
1.			to
2.			to
3.			to

Precautions:	
Frequency of checks:	

VII. REQUESTED TREATMENT

Requested Treatment: ☐ SA Rehabilitation ☐ Detoxification ☐ Inpatient Psychiatric

Are you requesting EPSDT referral/services? ☐ Yes ☐ No

Admission Status: ☐ Elective ☐ Emergency ☐ Court-Ordered

Admission Date:	Number of days requested:	
Attending Physician Name:		Phone:

Inpatient services that will be provided to this recipient:

Discharge Plan and Discharge Criteria:

FA-12
Updated 01/30/2019 (pv10/01/2015)

Page 3 of 4

Prior Authorization Information, FA-12, continued

– The last page contains information regarding the Certificate of Need (CON).

– This page must be signed and dated by the physician.

– Must be accompanied by an individualized plan of treatment with active participation by the recipient and their family, when applicable.

Prior Authorization Request
Nevada Medicaid and Nevada Check Up
Inpatient Mental Health

Certificate of Need

REQUESTED ADMISSION DATE: _____ / _____ / _____

SERVICE TYPE: ☐ Inpatient Psychiatric   ☐ Residential Treatment Center (RTC) Initial Request

RECIPIENT INFORMATION

Recipient Name (Last, First, MI):

Recipient ID:	DOB:

CASE MANAGER INFORMATION

Does the recipient have a case manager? ☐Yes ☐No	Case Manager Name:
Mental Health Center:	Phone:
Case Manager Signature:	Date:

ADMITTING FACILITY INFORMATION

Facility Name:	NPI:
Phone:	Fax:

CERTIFICATION STATEMENTS

A physician acting within the scope of practice as defined by State law certifies the following:

1. Ambulatory care resources available in the community do not meet the treatment needs of the recipient listed above.

2. Proper treatment of the recipient's psychiatric condition requires inpatient or residential treatment services under the direction of a physician.

3. The services can reasonably be expected to improve the recipient's condition or prevent further regression so that services will no longer be needed.

PHYSICIAN CERTIFICATION (required)

Name:	Title:
Signature:	Date:
Additional Notes:	

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

FA-12
Updated 01/30/2019 (pv10/01/2015)

Page 4 of 4

Prior Authorization Information, Concurrent Review

– All requests are to be made using form FA-14 and uploaded to the Provider Web Portal.

– Requests for concurrent stay may not exceed seven days, except for retrospective reviews.

– Each prior authorization must stand on its own; therefore, two to three 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 a 6, after the initial dates of service there should not be any unspecified diagnoses or remaining rule out diagnoses.

Prior Authorization Information, FA-14

– The FA-14 is used when requesting Concurrent Reviews, Reconsiderations or Retro Authorizations.

– **Section I (Recipient Information)**

– **Section II (Facility Information)**

– **Section III (ICD-10 Diagnosis)**

– **Section IV (Clinical Information)**

Prior Authorization Request
Nevada Medicaid and Nevada Check Up
Inpatient Mental Health Concurrent Review

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

REQUEST DATE: _____ /_____ /_____

REQUEST TYPE: ☐ Concurrent Review   ☐ Reconsideration
☐ Retrospective Authorization – Date of Eligibility Decision_____

NOTES:

I. RECIPIENT INFORMATION		
Recipient Name:		
Recipient Medicaid ID:	DOB:	Age:

II. FACILITY INFORMATION	
Facility Name:	NPI:
Address (include city, state, zip):	
Phone:	Fax:

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

IV. CLINICAL INFORMATION		
Date of Admission:	Number of days requested:	Requested Start Date:
Service: ☐ Acute ☐ Skilled		
Are you requesting EPSDT referral/services? ☐ Yes ☐ No	This request is for a(n): ☐ Youth ☐ Adult	
Date of physician's initial admission assessment:		
Special precautions for this recipient: ☐ SP ☐ Aggression ☐ Elopement ☐ Other:		
Intervals: ☐ q15 ☐ q30 ☐ q 1 hour ☐ Routine ☐ Other:		

Current Medication(s)	Dosage	Start Date
1.		
2.		
3.		

If applicable, list the most recent lab levels for the above medications:

Describe the recipient's current mental status:

FA-14
Updated 01/30/2019 (pv10/01/2015)

Page 1 of 2

Prior Authorization Information, FA-14, continued

- **Section IV, continued**
  - Input recipient's activities.
  - Provide the recipient's individualized treatment plan.
  - Provide medical justification.
  - Indicate the recipient's date of discharge.

Prior Authorization Request
Nevada Medicaid and Nevada Check Up
Inpatient Mental Health Concurrent Review

Describe recipient's participation in groups and activities:

Describe recipient's current individualized treatment plan and goals (*please update as appropriate*):

Discuss justification for continued services at this level of care (*evaluation of risk and level of acuity to demonstrate medical necessity for number of days being requested for review*):

Recipient's Estimated Date of Discharge:

Describe the discharge plan for this recipient (*note placement options and efforts to discharge*):

This referral/authorization is not a guarantee of payment. Payment is contingent upon eligibility, benefits available at the time the service is rendered, contractual terms, limitations, exclusions, terms & conditions set forth by the benefit program. The information contained on this form, including attachments, is privileged & confidential & is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If this communication has been received in error, the reader shall notify the sender immediately and shall destroy all information received.

FA-14
Updated 01/30/2019 (pv10/01/2015)

Page 2 of 2

Retrospective Authorizations

Retrospective Authorizations

– Nevada Medicaid authorizes only Medicaid eligible clients, not pending eligibility.

– 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). Check "Retrospective Authorization" at the top of the form.

– 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.

– If a recipient loses eligibility and it is later reinstated, submit a retrospective authorization for any prior dates. The retrospective authorization request must be attached to the original prior authorization number which included specific dates of service that were denied for loss of eligibility.

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 https://www.medicaid.nv.gov/providers/forms/forms.aspx

    – 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.

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.

– ICD-10 diagnosis codes must be utilized to include the correct code and narrative disorder.

– Failure to provide all pertinent medical information as required by Nevada Medicaid will result in authorization denial.

– Inpatient days not authorized by Nevada Medicaid are not covered.

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.

Submitting a Prior Authorization via the EVS Secure Provider Web Portal

Care Management Tab
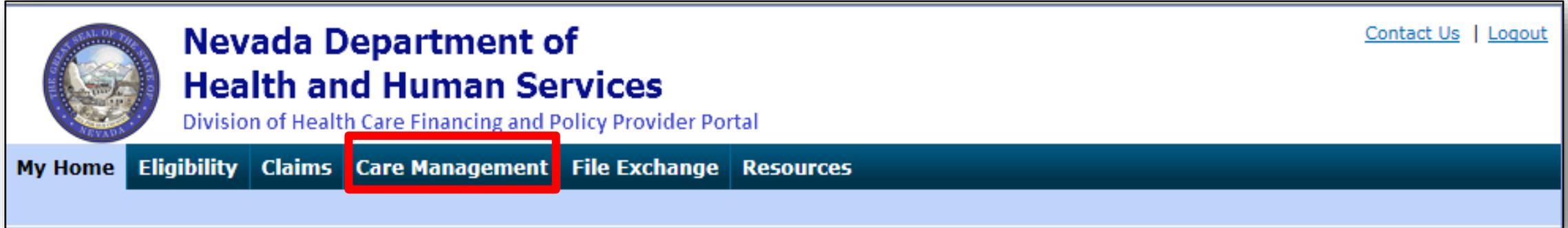
Create Authorization

— 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 Creating an Authorization Request

Before Creating 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

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.

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

Create Authorization

* Indicates a required field.

◉ Medical   ○ Dental

*Process Type [Home Health ▾]   Expand All | Collapse All

Requesting Provider Information   [−]

Provider ID 1831573690   ID Type NPI   Name HOSPITALIST SERVICES OF NEVADA-MANDAVIA

Recipient Information   [−]

⬡ 6

*Recipient ID [43827875678]
Last Name ABIEGUT   First Name ABYNNRYP
Birth Date 04/10/1928

Referring Provider Information   [−]

Referring Provider same as Requesting Provider ☐

Select from Favorites [No favorite providers available. ▾]

Provider ID [   ] 🔍   ID Type [▾]   Name   Add to Favorites ☐

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 list. 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.**

Submitting a PA Request, continued

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.

Submitting a PA Request, continued

If you click the **Add** button with an invalid diagnosis code, an error will display. Ensure the diagnosis code is correct, up-to-date with the selected **Diagnosis Type**, and does not include decimals.

Submitting a PA Request, continued

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.

Submitting a PA Request, continued

12. Enter detail regarding the service(s) provided into the **Service Details** section.
13. Click the **Add Service** button.

Submitting a PA Request, continued

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.

Submitting a PA Request, continued

14. Choose the type of attachment being submitted from the **Attachment Type** drop-down list.

Submitting a PA Request, continued

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.

Submitting a PA Request, continued

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.

Nevada Medicaid Psychiatric Hospital (Inpatient) Provider Training

Submitting a PA Request, continued

After the **Confirm** button has been clicked, an "Authorization Tracking Number" will be created. This message signifies that the PA request has been successfully submitted.

Submitting a PA Request, continued

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.

Viewing the Status of PAs, continued

6. Review the details listed in the **Decision / Date** and **Reason** columns.

Viewing the Status of PAs, continued

Service Provider / Service Details Information

Provider ID 1831573690   **ID Type** NPI   **Name** HOSPITALIST SERVICES OF NEVADA-MANDAVIA

From Date	To Date	Units	Remaining Units	Amount	Code	Medical Citation	Decision / Date	Reason
01/12/2018	01/12/2019	10	10	—	CPT/HCPCS 0003F-INACTIVE TOBACCO USE, NON-SMOKING	—	Certified In Total 01/12/2018	—

In the **Decision / Date** column, users may see one of the following decisions:
- **Certified in Total:** The PA request is approved for exactly as requested.
- **Certified Partial:** The PA request has been approved, but not as requested.
- **Not Certified:** The PA request is not approved.
- **Pended:** The PA request is pending approval.
- **Cancel:** The PA request has been canceled.

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

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).

Viewing the Status of PAs, continued

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

Edit   View Provider Request   Print Preview

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

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

Status Information

Select status to return authorization service lines with the chosen status.

D   **Status**

- Cancel
- Certified In Total
- Certified Partial
- Not Certified
- Pended

Recipient Information

Recipient information is not mandatory. ~~You can either enter~~ the Recipient ID; or the Last Name, First Name, and Birth Date.

D. **Status:** Select a status from this list to narrow search results to include only the selected status.

Searching for PAs, continued

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 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

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 a user is requesting 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 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.

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

Submitting Additional Information, continued
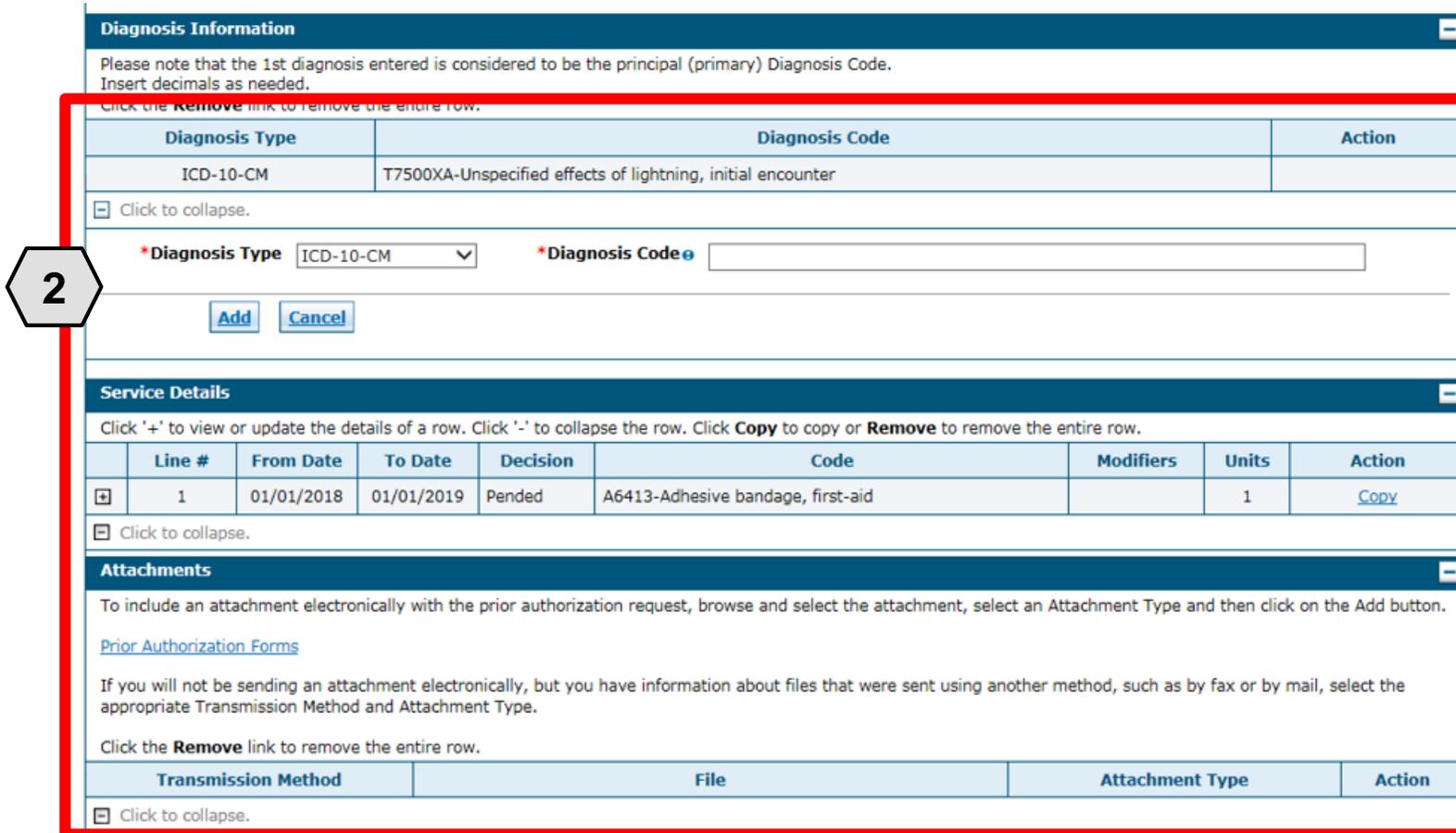
Diagnosis Information

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

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

Diagnosis Type	Diagnosis Code	Action
ICD-10-CM	T7500XA-Unspecified effects of lightning, initial encounter	

Click to collapse.

*Diagnosis Type ICD-10-CM ▾   *Diagnosis Code ⓘ [_____]

[Add] [Cancel]

Service Details

Click '+' to view or update the details of a row. Click '-' to collapse the row. Click **Copy** to copy or **Remove** to remove the entire row.

	Line #	From Date	To Date	Decision	Code	Modifiers	Units	Action
⊞	1	01/01/2018	01/01/2019	Pended	A6413-Adhesive bandage, first-aid		1	Copy

Click to collapse.

Attachments

To include an attachment electronically with the prior authorization request, browse and select the attachment, select an Attachment Type and then click on the Add button.

Prior Authorization Forms

If you will not be sending an attachment electronically, but you have information about files that were sent using another method, such as by fax or by mail, select the appropriate Transmission Method and Attachment Type.

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

Transmission Method	File	Attachment Type	Action

Click to collapse.

2. Add additional diagnosis codes, service details and/or attachments.

Submitting Additional Information, continued

3. Click the **Resubmit** button to review the PA information.

Submitting Additional Information, continued

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.

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.

- Denied dates of service cannot be requested as a concurrent review. Those dates of service may only be appealed.

Reconsideration Request

– If the provider attempts to introduce new or additional clinical information, the peer-to-peer will be terminated and the provider will be advised to submit a reconsideration review.

– A reconsideration review is a one-time review of denied/modified services.

– Reconsiderations can be uploaded via the provider portal by completing an FA-29B form and uploading to the "File Exchange" on the Provider Web Portal.

– Change the start date and number of days requested to reflect only those days that were denied by the physician.

– Additional medical documentation is reviewed to support the medical necessity.

– The information is reviewed by a different clinician than the clinician who 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.

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 the services that 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

Residential Treatment Center (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 RTCs.

– 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.

– Review the Medicaid Services Manual Chapter 400 Section 403.8A.5: Criteria for Exclusion from RTC Admission, in order to see if the recipient meets criteria for placement.

Coverage and Limitations

Absences

– In special circumstances, Nevada Medicaid may allow up to an eight-hour pass from the acute hospital without denial of payment.

– Absences may include, but are not limited to:

  – A trial home visit

  – A respite visit with parents (in the case of a child)

  – A death in the immediate family

– The hospital must request prior authorization from Nevada Medicaid for an absence expected to last longer than eight hours.

– There must be a physician's order that a recipient is medically appropriate to leave on the pass and the therapeutic reason for the pass must be clearly documented in the chart prior to the issuance of the pass.

– Upon the recipient's return, the pass must be evaluated for therapeutic effect and the results clearly documented in the recipient's chart.

Provider Responsibilities

Medicaid Form NMO-3058 (Admit/Discharge/Death Notice)

– All hospitals are required to submit Form NMO-3058 to their local Welfare District Office whenever a hospital admission, discharge or death occurs.

– Failure to submit this form could result in payment delay or denial.

– To obtain copies of Form 3058-SM, please contact the Welfare District Office or visit their website at https://dwss.nv.gov/uploadedFiles/dwssnvgov/content/Home/Features/Forms_3058-SM.pdf

NEVADA STATE DIVISION OF WELFARE AND SUPPORTIVE SERVICES
ADMIT / DISCHARGE / DEATH NOTICE
FOR NURSING, ICF/MR, AND ACUTE FACILITY TRACKING USE
(Must be submitted within 72 hours of occurrence or notification of pending Medicaid status)
DO NOT USE FOR LEVEL OF CARE CHANGES

SECTION I. Information in this section MUST MATCH Medicaid and Social Security records. Refer to patient's/resident's Medicaid Card, Legal Notice of Decision or access the Electronic Verification of Eligibility system. *(This section must be completed for all submissions.)*

Type of Medicaid Eligibility: *(Please check one)* ☐ MAABD ☐ Child Welfare ☐ TANF
CURRENT STATUS: ☐ Medicaid Eligible ☐ Medicaid Pending

Facility Submitting Form: *(Please do not use initials)* | Medicaid Provider Number: | Attending Physician:

Medicaid Billing No. (11 digits): *(Please complete, even if pending)* | *Aid Code: | Social Security No.: | Date of Birth: MO / DY / YR | Sex: ☐ M ☐ F

Patient's/Resident's Last Name: | Patient's/Resident's First Name: | M.I.:

*Aid Code to be completed if known by accessing one of the above three sources. DO NOT contact eligibility hot lines to obtain.
If above information is for a newborn, complete the following:

Newborn's Mother's Last Name: | First Name: | Medicaid Billing No. (11 digits): | Social Security No.:

SECTION II. Complete either Section A. or B.

A. ADMISSION INFORMATION: *(Complete this information only if being sent as an Admit Notice)*
ADMIT DATE TO THIS LEVEL OF CARE *(Regardless of Payment Source)*
MO / DY / YR

* ADM CODE: *(See below)* | Patient/Resident Admitted From: *(Include name. Do not use initials.)*

B. DISCHARGE/DEATH INFORMATION: *(Complete this area only if being sent as a Discharge/Death Notice)*
DISCHARGE OR DEATH DATE: MO / DY / YR | WAS THIS STAY PRIMARY MEDICARE? *(for nursing facility discharges only)* ☐ YES ☐ NO
**DIS CODE: *(See below)* | Patient/Resident Discharged To: *(Include name)*

Notice Completed by: _____ | Telephone: _____

*ADM(ission) Code:
B from ACUTE Level
C from SKILLED NURSING Level
D from INTERMEDIATE CARE Level
E from INDEPENDENT LIVING

**DIS(charge) Code:
B to ACUTE Level
C to SKILLED NURSING Level
D to INTERMEDIATE CARE Level
E to INDEPENDENT LIVING Arrangement
F PATIENT/RESIDENT DECEASED

SEND TO THE LOCAL DISTRICT OFFICE.

DISTRIBUTION: WHITE – Local Welfare and Supportive Services District Office   3058 – SM   (8/03)

Reimbursement

– Nevada Medicaid reimburses for admissions certified by Nevada Medicaid to a:

  – Psychiatric unit of a general hospital, regardless of age; or

  – Psychiatric hospital (Institution for Mental Diseases) for recipients under age 21 or 65 or older.

– For recipients under age 21 who are in the custody of the public child welfare agency, Nevada Medicaid reimburses for inpatient mental health services only when:

  – The child welfare agency also approves the admission/placement (this does not apply to placements at State-owned and operated facilities); and

  – The admission is certified by the QIO-like vendor.

Reimbursement, continued

–   Institutions for Mental Disease (IMD) — In accordance with 42 CFR 435.1009(2), Federal Financial Participation (FFP) is not available for individuals under the age of 65, unless they are under age 22 (or under 21 if they haven't met the following):

    –   Coverage of services for ages 21 up to 22 years – If a recipient is receiving services immediately prior to turning age 21, the services continue until:

        –   The individual no longer requires the services or

        –   The date the individual reaches 22.

–   In this extenuating circumstance, IMD service may continue until age 22. The regulation requires that the recipient must be receiving services immediately prior to age 21 and continuously up to age 22. Services cannot begin during the 21st year.

Reimbursement, continued

– Nevada Medicaid FFS shall not reimburse for any service for individuals who are ages 22-64 that are in an IMD which is defined as:

  – A hospital, nursing facility or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, and also provides for medical attention, nursing care and related services.

  – Whether an institution is an IMD is determined by its overall character being that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.

– Medicare crossover claims involving recipients ages 22-64 (or 21-64), in free-standing psychiatric hospitals, or IMDs, are reimbursable only if the recipient is a QMB — in these instances Medicaid may reimburse for copays and/or deductibles for Qualified Medicare Beneficiaries (QMB) while in an IMD up to the Medicaid allowable amount.

– However, QMB claims denied by Medicare are also denied by Nevada Medicaid.

Reimbursement if Prior Resources Involved

– Pursuant to federal law, Medicaid is the payer of last resort whenever any other resources may be responsible for payment.

– Prior resources include but are not limited to:

  – Medicare

  – Labor Unions

  – Worker's Compensation Insurance carriers

  – Private/group insurances

  – CHAMPUS

– Exceptions where Medicaid is primary instead are:

  – Bureau of Family Health Services

  – Indian Health Services

  – Ryan White Act and Victims of Crime

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 Information: https://www.medicaid.nv.gov/providers/BillingInfo.aspx

– Medicaid Services Manual: http://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSM/MSMHome/

Contact Nevada Medicaid

Contact Nevada Medicaid

- 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