

March 25, 2016  
Announcement 1104

## **Attention Provider Type 39: Prior Authorization Reminders for Adult Day Health Care Services**

Adult Day Health Care (ADHC) providers (provider type 39) are required to do the following when submitting requests for prior authorization.

1. Do not re-fax your request for review unless specifically asked to do so. Your request for review should appear in the Provider Web Portal within five (5) business days from the date of receipt. Be advised that the date the request is received is not calculated as the first day.
  - a. Providers should use the Provider Web Portal to check the status of a request.
  - b. If the provider is not yet registered to use the Provider Web Portal, please go to the login page (<https://www.medicaid.nv.gov/hcp/provider/Home/tabid/135/Default.aspx>) at [www.medicaid.nv.gov](http://www.medicaid.nv.gov) and register.
  - c. If there is still a question, providers may call Prior Authorization Customer Service at (800) 525-2395.
2. Use the current prior authorization request form [FA-17](#), dated 03/25/2016 or later. Use of any other form will delay the completion of the requested review.
3. Requests for ADHC are based on a monthly frequency, so the end date indicated must be the last day of a month.
  - a. If the request has a start date of the 1st through the 15th of the month, the latest end date that may be requested is one year from the end of the previous month.
  - b. If the request has a start date of the 16th through the 31st of the month, the latest end date that may be requested is one year from the end of the current month.Examples:
  - A start date of 03/15/2016 may have an end date as late as 02/28/2017.
  - A start date of 03/16/2016 may have an end date as late as 03/31/2017.
4. The requested authorization begin date cannot precede Hewlett Packard Enterprise's receipt date of a completed request. Be sure to include the requested number of days per week.
5. Do not fax a copy of the Tuberculosis (TB) testing or other medical records. Please maintain this information in the recipient's file. Include only the following with your submission:
  - a. FA-17 including signature that the recipient is aware they can select the ADHC provider of choice
  - b. Universal Needs Assessment
  - c. Care Plan
  - d. Physician Evaluation and order of ADHC services
6. A current ICD-10 diagnosis is required.