PROVIDER QUICK TIP GUIDE:
Submitting INPATIENT PSYCHIATRIC AND RTC/PRTF Prior Authorization Requests

INTRODUCTION

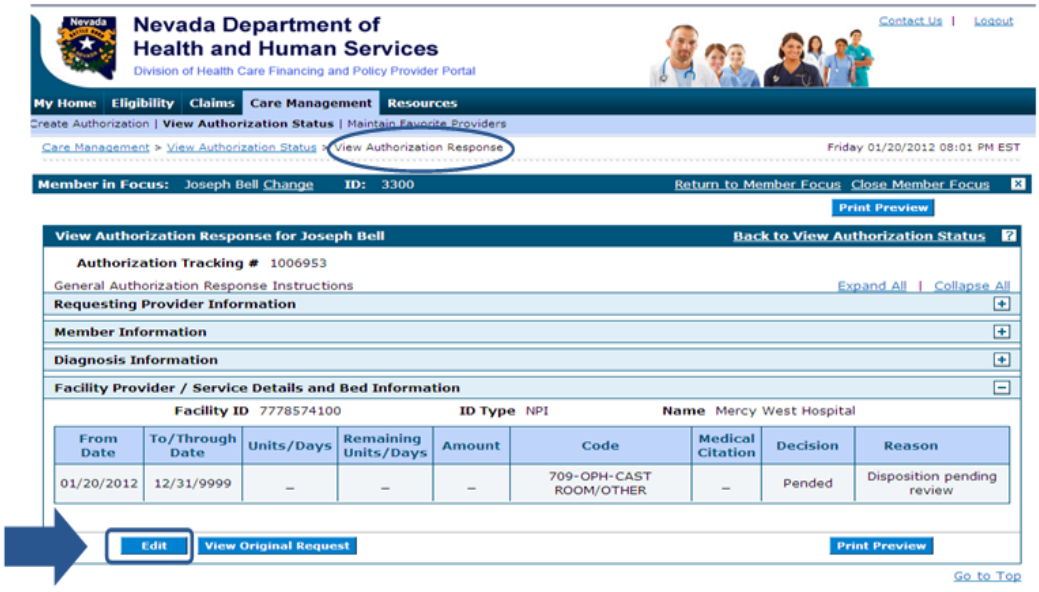
This document provides tips for submitting an **inpatient psychiatric or residential treatment center (RTC)/psychiatric residential treatment facility (PRTF)** prior authorization (PA) request to assist in reducing the need for PA requests to be pended for additional information and to assist in a quick turnaround of provider requests.

PROVIDER WEB PORTAL SUBMISSION OF A CONTINUED STAY REQUEST:

- When submitting a request for a continued stay for a recipient, providers should use the edit button on the existing request located in the Provider Web Portal.
- Continued stay requests should not be submitted as a new request for authorization.
- If the original result was denied, then the edit button will not display and the provider will need to submit the request via the Provider Web Portal.

Prior authorization – initiate update to a PA:

Click the Edit button on the View Authorization Response page.



TIP: If the authorization is ineligible for an update, no Edit button displays.

DOCUMENTATION NEEDS:

Documentation submitted should be legible, accurate, sufficient and appropriate:

- Illegible handwritten notes will not be reviewed. Please type the notes.
- If there is information that needs to be brought to the reviewer's attention, such as the request is retro, this information must be attached to your submission.

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MAXIMUM NUMBER OF DAYS PER NON-RETRO REQUEST:

When submitting a request always request the appropriate number of days based on the clinical presentations. Below are the maximum number of days that can be considered:

- RTC/PRTF maximum number of days per request is 90.
- Inpatient maximum number of days per request is 7.

SUBMISSION OF FORM FA-29 FOR DATA CORRECTIONS:

- These are to be submitted via the Provider Web Portal.
- Always include the contact name and direct phone number of a person at your facility who can answer questions regarding the submission.
- When submitting form FA-29 (Prior Authorization Data Correction Form), provide a detailed explanation of the exact problem with the data that was previously submitted and what you expect the outcome of the data correction to accomplish.
- RTC/PRTF providers: Submit an FA-29 if the date of admission differs from the date of admission on the prior authorization. Please note that the prior authorization end date will remain the same if the actual admission date is after the originally approved PA request start date as medical necessity was only approved through this date. The only time the end date will change is if the recipient admits sooner than the originally approved PA request start date to match the number of units that were authorized.
- Inpatient Psychiatric and RTC/PRTF providers: Submit an FA-29 if the recipient is discharged on or before the last authorized date of service.

SUBMISSION OF FORM FA-29 TO AVOID OVERLAPPING SERVICES:

- Nevada Medicaid providers must submit form FA-29 to end services on a PA if the recipient terminates services or discharges prior to the end date on the PA. If form FA-29 is not submitted and the recipient seeks treatment elsewhere, the new PA may be denied due to overlapping services and cause delays in the recipient getting the needed services.

TERMINATION OF SERVICES:

- When a recipient has decided to terminate services with their existing provider, the prior authorization on file will be end dated and a Notice of Termination of Service letter will be generated. This letter serves as a notice to the providers that their prior authorization's end date has been updated.
- Current/new providers who are not able to get a prior provider to submit form FA-29 to end date their services (which is then causing an overlapping issue with getting the new provider's PA request to be approved) can utilize the FA-29A (Request for Termination of Service) form when submitting their PA request either originally or should it be pended for additional information related to this issue. Form FA-29A must be signed by the recipient/guardian and include the original provider's name and procedure codes that had been requested on their PA request.

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- Providers can contact the PA customer service line at (800) 525-2395 for information needed to complete the FA-29A if unable to get all the needed information from the recipient/guardian.

PRIOR AUTHORIZATION SUBMISSIONS:

When submitting a request for a review, please provide the following:

- Contact name and direct phone number of a person at your facility who can answer questions regarding the submission.
- Initial Request: Completed FA form (FA-12 for Inpatient, FA-15 for RTC/PRTF).
- Concurrent Request: Completed FA form (FA-14 for Inpatient, FA-13 for RTC/PRTF).
- Certificate of Need (CON) is to be signed. RTC/PRTF CON is signed by the physician at the receiving facility.

NON-EMERGENT HOSPITAL OR LEVEL OF CARE TRANSFERS:

- All non-emergent hospital-to-hospital transfers, in-state or out-of-state, must have an authorization in place prior to the transfer. Please see Medicaid Services Manual (MSM) Chapter 200 Hospital Services. The attending physician who is transferring the recipient is responsible for requesting the authorization prior to the transfer. The receiving hospital is responsible for confirming an approved authorization for a non-emergent transfer is in place prior to accepting the recipient.
- All non-emergent changes in Level of Care (LOC)/transfers between units within a hospital must have an authorization in place prior to the transfer.
- Having the authorization in place prior to a non-emergent transfer is intended to assure the receiving hospital or unit that the transfer is authorized as meeting medical necessity criteria.
- The Electronic Verification System (EVS) User Manual Chapter 4: Prior Authorization provides step-by-step instructions with screenshots for how to view the status of a prior authorization to ensure that a request has been submitted by a transferring hospital on behalf of a receiving hospital prior to admitting in a recipient. The receiving hospital can view the request status once the transferring hospital has informed the facility of the PA number that has been submitted on their behalf, or it can be searched for by using the recipient ID number.

CONCURRENT REQUESTS:

When submitting a concurrent request:

- Count the actual number of calendar days on your existing request.
- RTC/PRTF: Please be aware that 90 days is the maximum number of days that can be considered for a single RTC/PRTF request. The PA is through the last authorized date on the PA and therefore the next date would be the start date on a request for continued stay/concurrent review.
    - Best practice recommendation for RTC/PRTF providers is to submit the concurrent PA requests in the 5-15 business day window prior to the current end date.
- INPATIENT: Please be aware that seven (7) days is the maximum number of days that can be considered for a single Inpatient request. The last day on the PA is considered the last authorized

date and therefore the first date for a concurrent review would be the anticipated date of discharge after the previous authorized treatment period.

RETROSPECTIVE SUBMISSIONS:

When submitting a request for a retrospective review, **please provide the following**:

- Provider is to complete the appropriate form and is asked to provide only pertinent clinical information. This information would substantiate the medical necessity for inpatient care. Providing voluminous clinical data slows the review process.
- Please do not submit an entire medical record. If this occurs, it will delay the review process. A summary of 10 pages or less is suggested.
- Provider may request a combination of acute and skilled days. It is essential that the level of care and requested dates/days be clearly documented.
- Contact name and direct phone number of a person at your facility who can answer questions regarding the submission.
- The Date of Decision (Eligibility).
- Document that a request is being made for a retrospective review.
- Sufficient clinical documentation to support medical necessity for the entire stay (some are very long stays).
- Summary physician notes for the entire stay.
- Admit and Discharge Summaries.
- Providers are advised that when the patient is inpatient and determined eligible *during their inpatient stay,* the provider must request prior authorization within 10 business days of the date of eligibility decision (refer to the Prior and Retrospective Authorization chapter in the Billing Manual).
- If a recipient is determined eligible for Medicaid benefits *after* service is provided (or after discharge), a retrospective authorization may be requested within 90 calendar days from the date of eligibility decision (refer to the Prior and Retrospective Authorization chapter in the Billing Manual).

RETRO REQUESTS When MEDICARE is exhausted:

When submitting:

- Submit within 30 calendar days of receipt of Medicare notification that Medicare payments are exhausted.
- Mark the submission as Retro for this reason.
- Include a copy of the Medicare benefits statement, denied Explanation of Benefits (EOB) or remittance advice that shows Medicare benefits are exhausted.

ADVERSE DECISIONS:

Details and specific information for the recipient's situation must be included to help support the need for an acute inpatient level of care. PAs that are generalized or vague make it difficult to determine whether a recipient truly meets medical necessity.

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When a request has been denied or modified (partially approved) by the physician:

- You may request a peer-to-peer within 10 business days of the notice of decision date.
- A provider may request a peer-to-peer Review by emailing nvpeer_to_peer@gainwelltechnologies.com within 10 business days of the adverse determination. The purpose of the peer-to-peer review is to hear the rationale from the Nevada Medicaid physician as to why the PA request was denied or modified.
- If it is felt additional information needs to be submitted that hadn't been submitted originally to justify the medical necessity, a provider may request a reconsideration within 30 calendar days of the notice of decision date (90 calendar days for RTC/PRTF).
- You may not request a concurrent review for denied dates of service. Those dates of service may be appealed.
- For hospital inpatient days that were denied at the acute level of care, the provider may request these denied dates of service at a lower level of care. The dates of service requested at the skilled level of care do not need to be denied first at the acute level of care. Please reference Administrative Days policy in the current MSM Chapter 400, Section 403.11 for more information.

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 will be denied if the recipient was not at an acute inpatient level of care facility at least one 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.

CHECK THE FORM FOR ACCURACY AND COMPLETENESS:

When submitting:

- Is there a start date and is it correct?
- Is there a number of days requested?
- Does the portal entry match the attachment?
- If the request is concurrent, is your start date correct?
- Did you include the signed CON for initial request?
- RTC/PRTF Initial request – did you include comprehensive psychiatric assessment current within 6 months and a signed CON?

Notes:

This Provider Quick Tip Guide is meant to be used as a reference in conjunction with the Billing Manual for Nevada Medicaid and Nevada Check Up.

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For more information regarding PA submissions, forms and/or billing information, please refer to the Billing Manual on the Providers Billing Information webpage at www.medicaid.nv.gov. Forms can be found on the Providers Forms webpage at www.medicaid.nv.gov.

Training information is available on the Provider Training webpage.

Providers may contact the PA customer service unit at (800) 525-2395 for questions regarding PA submissions and forms.